

# Richard C. Wender, MD

Chief Cancer Control Officer, American Cancer Society, Inc.; Chair, National Colorectal Cancer Roundtable



# 80% by 2018: *We Have A (Strategic) Plan*

**Richard C. Wender**  
Chief Cancer Control Officer  
American Cancer Society, Inc.  
November 21, 2014



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Reaching **80%** screening by **2018** ...

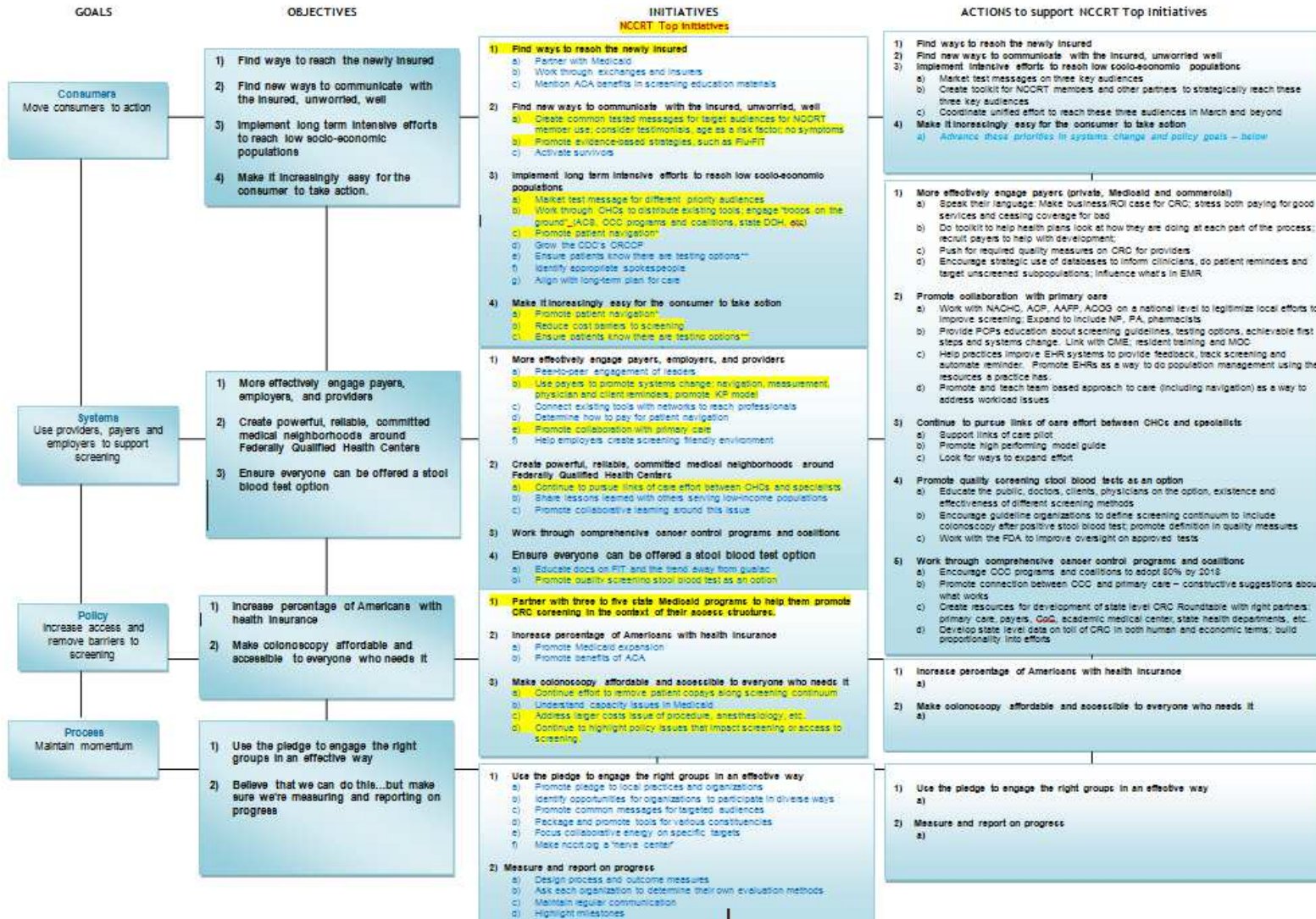
... I can see it!



# Our Strategic Plan



80% by 2018 Strategic Plan  
Draft: 08.04.2014



# 80% by 2018 Strategic Mapping Process

## Big Picture Mapping Session

*June 10, 2014*

- 23 organizations represented
- Session used to begin development and prioritization of draft 80% by 2018 strategic plan

## Public Awareness Task Group Meeting

*July 17, 2014*

- 26 organizations represented
- Finalizing 80% by 2018 communications plan



# 80% by 2018 Strategic Mapping Process

## Professional Education and Practice Task Group Meeting

*July 30, 2014*

- 23 organizations represented
- Develop a 2015 provider outreach/systems change plan around 80% by 2018

## Evidence-Based Education and Outreach Task Group Meeting

*November 19, 2014*


- 15 organizations represented
- Advise on evaluation and measurement of the 80% by 2018 effort





**We Have Studied; We Have Convened;  
We Have Planned**


***So what have we learned that will steer  
us to our 80% by 2018 goal?***



## **10 Lessons Learned in Year One of the 80% by 2018 Campaign**

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. Creating medical neighborhoods can be really challenging.



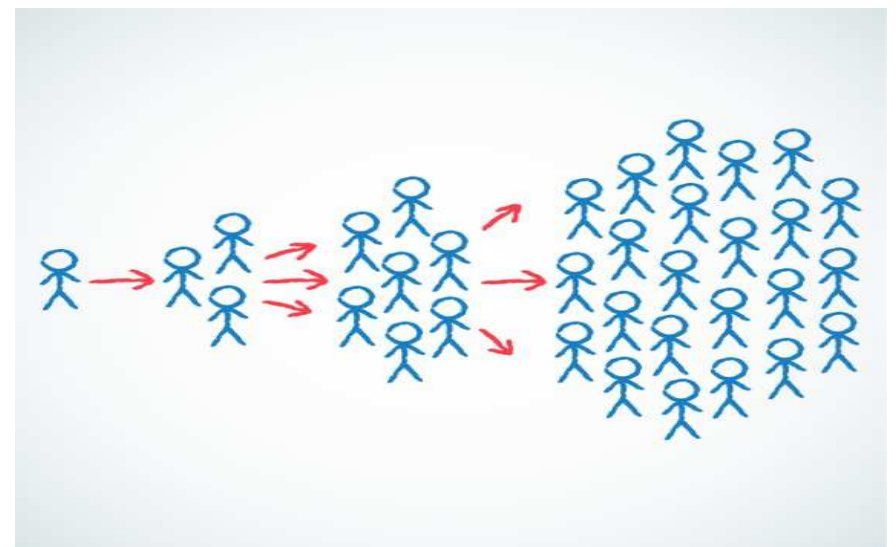


## **10 Lessons Learned in Year One of the 80% by 2018 campaign**

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.

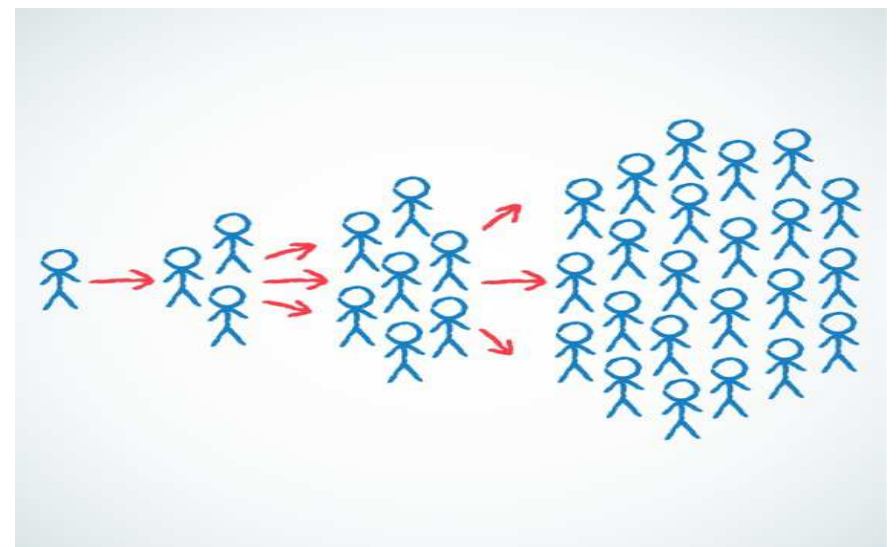
# 1. The 80% by 2018 Campaign Has Gone Viral

- 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.



# 1. The 80% by 2018 Campaign Has Gone Viral

- Diverse sets of organizations – from NGOs to hospital systems to the Commission on Cancer to Comp Cancer programs to professional groups to government agencies and many others – have stepped up to take a **leadership** role
- They **OWN** this goal!



# More and More Organizations Are Signing the Pledge



**Shared Goal: Reaching 80% Screened for Colorectal Cancer by 2018**

#### Background

Colorectal cancer is a major public health problem. It is the second leading cause of cancer death, and a cause of considerable suffering among more than 140,000 adults diagnosed with colorectal cancer each year. However, colorectal cancer can be detected early at a curable stage, and it can be prevented through the detection and removal of precancerous polyps.

#### Commitment

Our organizations stand united in the belief that we can eliminate colorectal cancer as a major public health problem. We have screening technologies that work, the national capacity to apply these technologies, and effective local models for delivering the continuum of care in a more organized fashion. Equal access to care is everyone's responsibility. We share a commitment to eliminating disparities in access to care. As such, our organizations will work to empower communities, patients, providers, community health centers and health systems to embrace these models and develop the partnerships needed to deliver coordinated, quality colorectal cancer screening and follow up care that engages the patient and empowers them to complete needed care from screening through treatment and long-term follow-up.

#### Pledge

The New York Citywide Colon Cancer Control Coalition (C5) is embracing the shared goal of reaching 80% screened for colorectal cancer by 2018.



# More Organizations Are Taking the Pledge



# More Organizations Are Taking the Pledge



# Engagement by the Numbers

<b>175</b>	# of participants registered for this meeting
<b>130</b>	# of number of participants usually attending this meeting
<b>13</b>	# of new/reactivated NCCRT members
<b>6</b>	# of pending applications
<b>3-4</b>	# of new members typically announced at NCCRT meeting



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**Let's Pledge to Maintain  
This Momentum ...**

*On the road to 2018*





# What do we have going for us?

Avenues and tools  
to reach  
professionals

Understanding of  
barriers and  
facilitators to  
screening

Strong presence on  
ground; programs  
for underserved

A network of Relay  
events, fun runs,  
etc.

Strong leadership  
in policy and  
advocacy

Survivors are  
energized and  
ready to go

Strong  
collaborative spirit

Right groups  
at the table

# What are the barriers?

Funding and  
resources

Funding and  
resources

Funding and  
resources

Funding and  
resources

Funding and  
resources

Funding and  
resources

Funding and  
resources

Funding and  
resources



# **We DON'T Have Enough Resources!**

Public health efforts will never be as well funded as we would like. They never are ...

***So let's get to 80% by 2018 anyway.***

## **2. We're Not Getting to 80% Without Relying on Primary Care**

- The basics of screening have not changed:
  - Everyone needs health insurance.
  - 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.**

# The Realities of Primary Care Practice

- Many competing priorities
- Many preventive care obligations
- Many have EMR's – but they don't always help
- **What will it take to help primary care clinicians lead the way to 80%?**



# Extraordinary National Leadership

- The American College of Obstetricians and Gynecologists has stepped up big time.
- The American Academy of Family Physicians has signed the pledge and re-joined the NCCRT.
- The National Association of Community Health Centers is all in.
- The American College of Physicians has pledged their support.
- **We need to engage all of the primary care organizations.**



# What Can We Do to Make it Easier for Primary Care Clinicians to Get This Done?

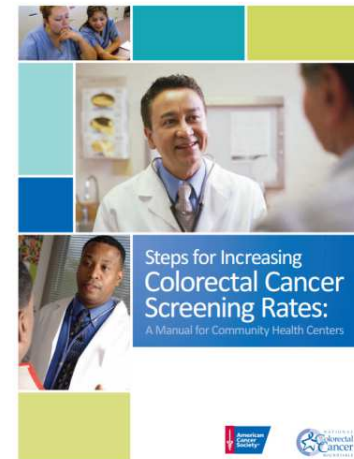
- Champions
- Education
- Incentives
- Facilitation
- Innovation
- Recognition



# *Working with Primary Care Practices*

## Promote collaboration with primary care.

- Provide PCPs education about screening guidelines, testing options, achievable first steps and systems change. Link with CME, **MD1**, resident training and MOC
- Help practices improve EHR systems to provide feedback, track screening and automate reminders. Promote EHRs as a way to do population management.





**Slide 24**

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**MD1**

Should we stick with the bubble format from the later slides?

Mary Doroshenk, 11/14/2014

## ***Systems: Working with Primary Care Practices***

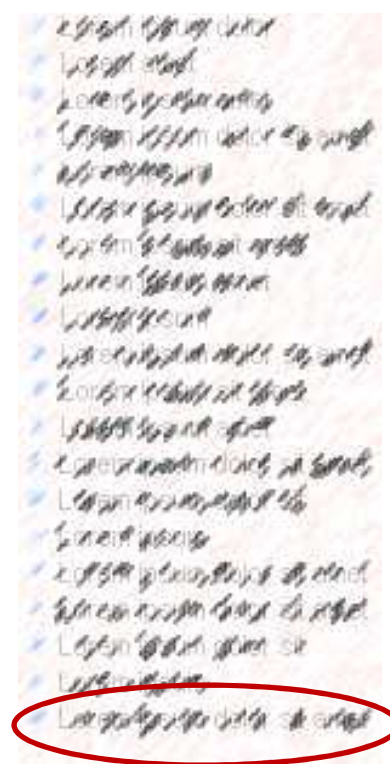
**Promote collaboration with primary care.**

- Work with NACHC, ACP, AAFP, ACOG to legitimize and promote local efforts to improve screening; Expand to include NP, PA, pharmacists
- Promote and facilitate team based approach to care as a way to address workload issues



### 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

- Strong existing CRC task groups and coalitions in California, Delaware, Kentucky, Maryland, Minnesota, New York, and South Carolina
- Several states are pursuing their own state CRC roundtable: West Virginia, Louisiana, Iowa, North Carolina, Georgia, Wisconsin, Montana, South Dakota,



# What Do States Want and Need?

- Data
  - What is our starting screening rate?
  - How do we set and measure interim targets?
  - What regions offer the most opportunity?
- Goals
  - Some states have embraced a more achievable goal, such as 70% by 2020.
  - Set a state goal and get state-wide, multi-stakeholder buy-in.
- Ideas
  - What is working in similar states?
  - What screening strategies should we adopt?
  - How can we ensure that colonoscopy is broadly available?

## 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.**

# Let's Be Little League: Everyone's a Winner

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**... 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 Difficult but 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 is intense





# How to Engage Health Care Plans and Insurers?

- A great role for state roundtables.
- Insurers need to hear from all interested constituents – including hospitals, employers, not-for-profits, and clinicians – that achieving 80% by 2018 is a shared, important goal.
- Recognize and celebrate high-performing health plans.
- Let's learn from some health plans who are leading.
- The NCCRT will form a Health Plan Task Group.

# Let's Get Some CEOs and Large Employers to Join the Cause

- Large employers matter.
- If CEOs want an engaged health care plan, they can help bring this about.

***Let's prove to the plans that diverse organizations can join together to accomplish something remarkable.***

## 5. Creating Medical Neighborhoods Can Be Really Challenging

- We are continuing to pursue **links of care** between CHCs and specialists.



## Links of Care – *Background*

- June 2012 – The NCCRT co-hosted a meeting with the National Association of Community Health Centers to identify strategies for improving colorectal cancer in community health centers.
- February 2013 – Assistant Secretary for Health Dr. Howard Koh convened a group to advance work on colorectal cancer screening rates, particularly among the underserved.



## Links of Care – *Background*

- June 2013 – Strategy paper published. Need to improve access to specialty care after CRC screening highlighted as a major barrier.
- September 2013 – Leaders of professional societies along the care continuum met to review high performing models; commit to pilot effort.
- March 2014 – RFP announced.
- May 30, 2014 – Three pilot sites were selected.



# Links of Care – *Strategy Paper*

CA CANCER J CLIN 2013;000:000-000

## Strategies for Expanding Colorectal Cancer Screening at Community Health Centers

Mona Sarfaty, MD, MPH<sup>1\*</sup>; Mary Doroshenk, MA<sup>2</sup>; James Hotz, MD<sup>3</sup>; Durado Brooks, MD, MPH<sup>4</sup>; Seiji Hayashi, MD, MPH, FAAFP<sup>5</sup>; Terry C. Davis, PhD<sup>6</sup>; Djenaba Joseph, MD, MPH<sup>7</sup>; David Stevens, MD<sup>8</sup>; Donald L. Weaver, MD<sup>9</sup>; Michael B. Potter, MD<sup>10</sup>; Richard Wender, MD<sup>11</sup>

Community health centers are uniquely positioned to address disparities in colorectal cancer (CRC) screening as they have addressed other disparities. In 2012, the federal Health Resources and Services Administration, which is the funding agency for the health center program, added a requirement that health centers report CRC screening rates as a standard performance measure. These annually reported, publically available data are a major strategic opportunity to improve screening rates for CRC. The Patient Protection and Affordable Care Act enacted provisions to expand the capacity of the federal health center program. The recent report of the Institute of Medicine on integrating public health and primary care included an entire section devoted to CRC screening as a target for joint work. These developments make this the ideal time to integrate lifesaving CRC screening into the preventive care already offered by health centers. This article offers 5 strategies that address the challenges health centers face in increasing CRC screening rates. The first 2 strategies focus on improving the processes of primary care. The third emphasizes working productively with other medical providers and institutions. The fourth strategy is about aligning leadership. The final strategy is focused on using tools that have been derived from models that work. *CA Cancer J Clin* 2013;000:000-000. ©2013 American Cancer Society, Inc.

**Keywords:** colorectal cancer screening, community health centers, strategies or strategic planning, public health, quality/quality improvement, Patient Centered Medical Home

## **Systems: *Links of Care***

- Three grants in the amount of \$100,000 each over 18 months have been awarded to Federally Qualified Health Centers (FQHCs) networks and local system partners to decrease colorectal cancer mortality rates.
- The grant funding is intended to stimulate collaboration among local partners and support development of the long-term structures and relationships needed to improve access to specialists delivery of colorectal cancer screening.



## Links of Care – *Effective Models*

- James Hotz, MD, Medical Director, Cancer Coalition of South Georgia
- Colleen Schmitt, MD, Project Access/Founding Physician of Volunteers in Medicine, Chattanooga, TN
- Jason Beers, CEO, Operation Access, San Francisco and the Peninsula
- Lynn Butterly, MD, Principal Investigator and Medical Director, New Hampshire Colorectal Cancer Screening Program
- Dave Greenwald, MD, New York Citywide Colon Cancer Control Coalition (C5)
- Carla Ginsburg, MD, MPH, AGAF, Chair, Public Affairs and Advocacy Committee, American Gastroenterological Association



## Links of Care –*Key Characteristics*

- A **strong physician champion** can help coordinate high-level institutional commitment from GI partners and hospitals/health systems.
- Participation of a **neutral partner** to help negotiate effort.
- GIs and hospitals are often willing to provide pro bono services and care if **expectations are defined, business case is clear, burden is shared**, and follow-up is assured.



## Links of Care –*Key Characteristics*

- Volume can be managed if all parties work collaboratively and there is effective coordination/distribution of cases.
- High value is placed on **patient care management, program efficiency, and consistency of referral protocols** (e.g. standardized patient info forms).





# Just Donate One

- Volunteering service feels good.
- Let's ask every clinician to offer some free care **one time.**
- Some will like it . . . and will do it again.

## Links of Care –*Key Characteristics*

- Use of **patient navigators** effectively address concerns about no shows, prep, cultural/language barriers
- Form and leverage the ***right* partnerships**; understand what motivates each partner; **share the credit.**



## Links of Care – *Medical Professional Societies*

Professional societies supporting the effort:

- **Signed the Commitment Statement.**
- Agreed to promote the effort among their membership.
- **Identify physicians in the pilot locations** who are willing to support a local effort to improve links of care, patterned after that of the high performing models.



# Disseminating the Links of Care Model

- Engaging physicians who are in private practice poses a real challenge.
- Local, regional, and national meetings featuring 80% by 2018 can help.
- Hospital leadership is needed.
- The more local physician **Champions** we can enlist the better.
- **The business case for navigators is strong** – time for this to become a national standard.



## 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.







# Create a Culture of Wellness

- Emphasizing wellness is good business.
- ACS has tools to help assess corporate wellness and to institute a health improvement program.
- Colon cancer screening predominately works by **preventing** colon cancer and is highly cost-effective.

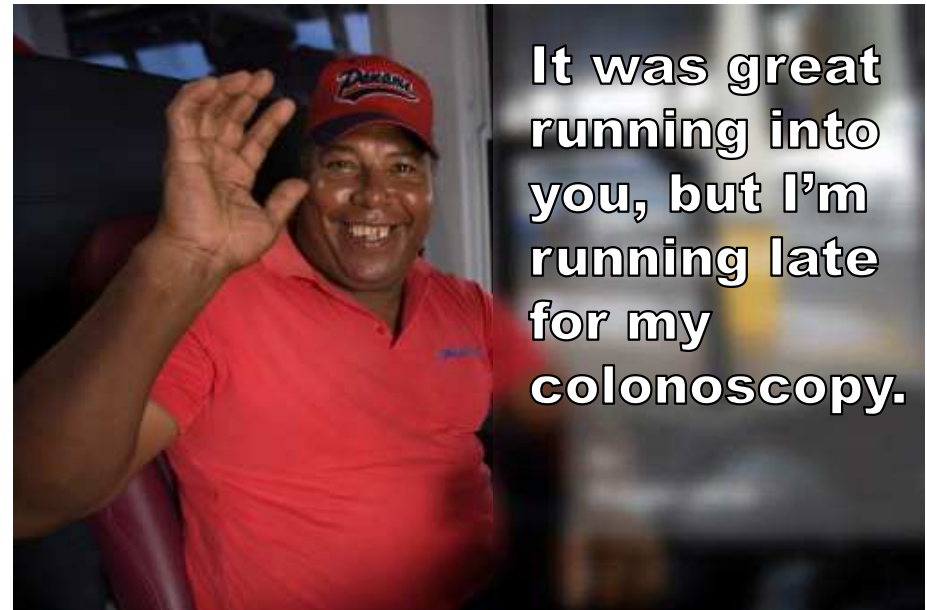
# Educate Employees and Their Families About Colon Cancer Risk

Almost all companies  
employ many  
**unworried well.**



# Make it Easier for Employees to be Screened

- Colonoscopy is the most complex cancer screening test.
- Requires a special diet and prep the day before.
- Requires a full day off from work.
- **Granting a day off for colonoscopy above the personal day allotment is powerful.**



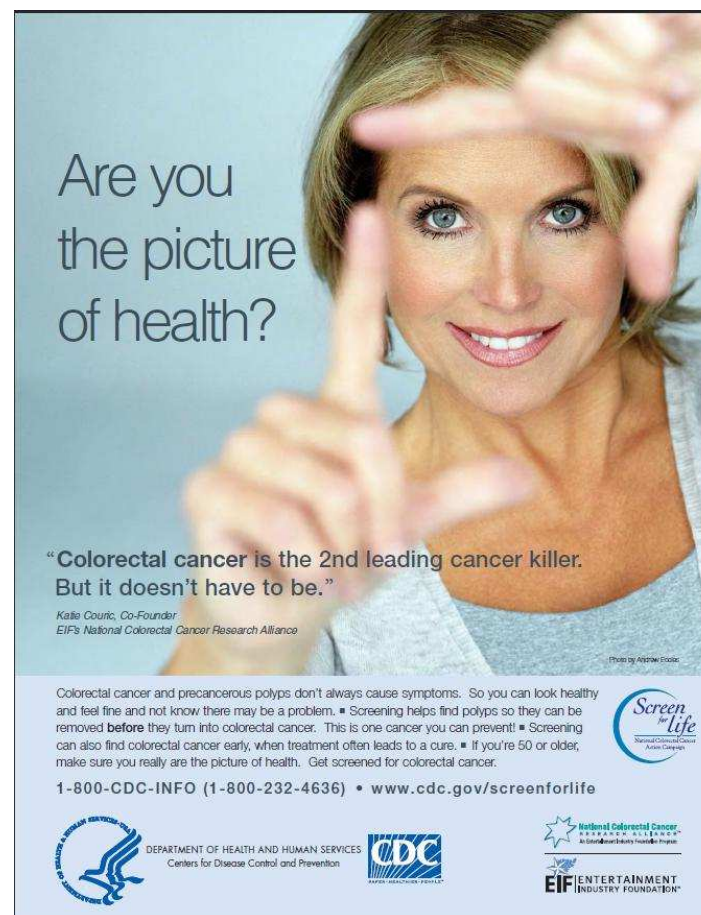
And make sure that employees know there is a great alternative to colonoscopy:

**An annual fecal immunochemical test with colonoscopy only for those who test positive.**



## Serve as Role Models

- CEOs are the **superstars** of their company.
- Talking about their own screening can have a local **Katie Couric effect**.



Are you  
the picture  
of health?


“Colorectal cancer is the 2nd leading cancer killer.  
But it doesn’t have to be.”


*Katie Couric, Co-Founder  
EIF’s National Colorectal Cancer Research Alliance*


Photo by Andrew Froese


Colorectal cancer and precancerous polyps don’t always cause symptoms. So you can look healthy and feel fine and not know there may be a problem. ■ Screening helps find polyps so they can be removed **before** they turn into colorectal cancer. This is one cancer you can prevent! ■ Screening can also find colorectal cancer early, when treatment often leads to a cure. ■ If you’re 50 or older, make sure you really are the picture of health. Get screened for colorectal cancer.


1-800-CDC-INFO (1-800-232-4636) • [www.cdc.gov/screenforlife](http://www.cdc.gov/screenforlife)

 DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Disease Control and Prevention

 **cdc**  
SAFER • HEALTHIER • PEOPLE™

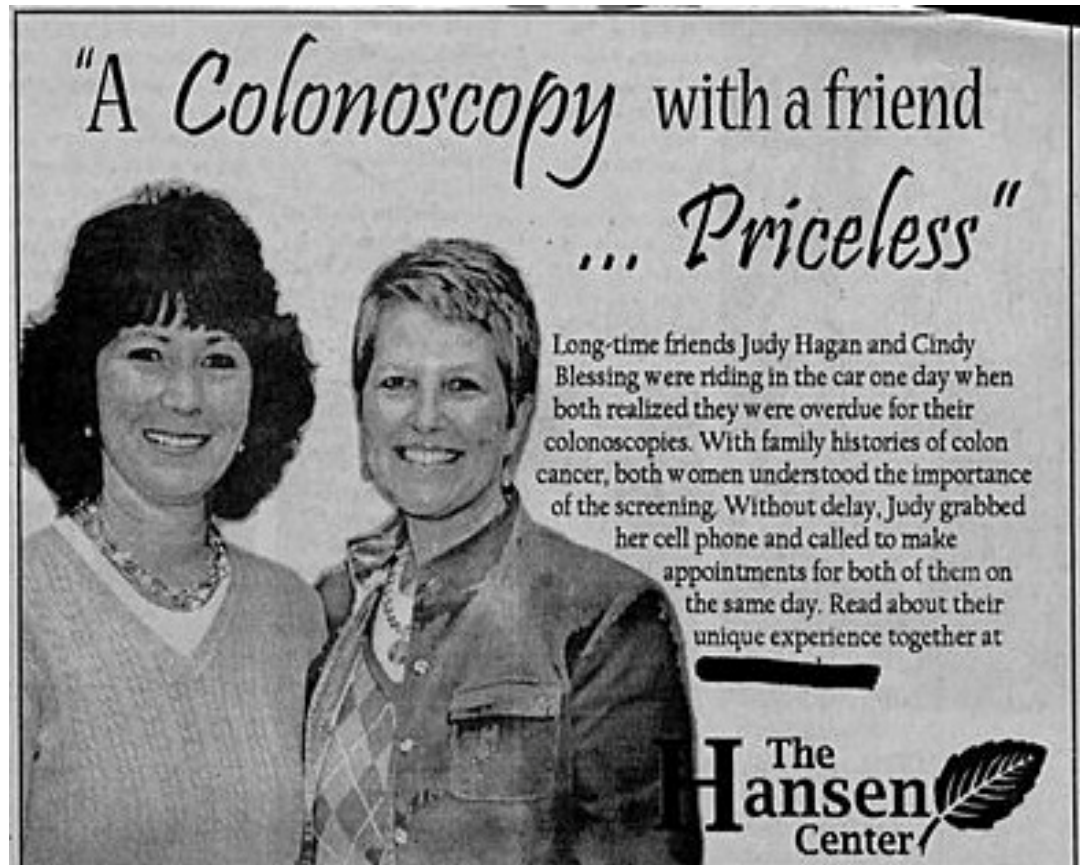
 National Colorectal Cancer  
RESEARCH ALLIANCE  
All Good Starts with Healthy People

 Screen  
for Life  
National Colorectal Cancer  
Research Alliance Campaign

 EIF ENTERTAINMENT  
INDUSTRY FOUNDATION™

## 7. We Need Tailored Messages to Reach the Unscreened

- We have conducted market research with a large group of unscreened Americans.
- General messages to encourage screening will not be effective.
- NCCRT members are ready to commit to common messages.



# 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.”*

#1 reason among 50-64 year olds & Hispanics

## #2: Lack of symptoms

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

Nearly ½ uninsured

## #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 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





# The Path to Screening

The unscreened are knowledgeable about CRC screening,  
but have **rationalized avoidance**

Make the case  
for early  
detection

Eliminate real  
& perceived  
barriers

Engage family  
& community  
networks

Align systems  
to reinforce  
messages

Elicit support  
& testimony  
from peers,  
survivors

De-stigmatize  
the test &  
offer options

Articulate  
disease  
profile &  
progression

Address  
financial  
concerns

Equalize with  
“competing”  
health  
concerns

Refine & test messages  
Identify influencers  
Dispatch messengers  
Deploy campaign assets

Activate communication  
channels  
Measure success  
Course-correct

# Micro-targeting to Inform Strategy & Messaging

## Newly Insured

- Nearly 50% of ACA enrollees are ages 45-64

## Insured, Unworried

- Utilize medical neighborhood (versus medical home)

## Low Socio-economic Populations

- Underserved; manifest health disparities; more likely to be uninsured

**Hispanic (53% screening rate)**

Caucasian

African American

Asian American/Pacific Islander

Native American/Alaska Native

# Critical Campaign Message Recommendations

*For All Targeted Groups*

CRC facts & importance of screening (Customize with race/ethnicity epidemiology data)

Testing options/alternatives

Cost/insurance information

Personalize the CRC risk and the screening benefits with survivor stories

- Continue to promote 80% by 2018 to national media
- Lend credibility to partners' efforts
- Recruit partners

**Slide 58**

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**MD2**

We just got the early report on the tested messages. Will Rich want to add that in, or should we hold off, so as to not steal Angela's thunder later in the day when she shares it?

Mary Doroshenk, 11/14/2014

## Consumers: *Move consumers to action – Actions*

### Implement an intensive effort to reach the unscreened

- Market test messages with three key audiences
- Create toolkit for NCCRT members and other partners to strategically reach these three key audiences
- Coordinate unified effort to reach these three audiences in March and beyond



## 8. Financial Barriers Persist as Major Obstacles to Screening

- The CDC colon cancer screening program is a critically important option.
- Some colonoscopies must be donated.
- Fecal immunochemical tests and high sensitivity guaiac FOBT are **GOOD, IMPORTANT, NECESSARY options.**
- NCCRT member organizations must lead strategies to reduce financial barriers.

## 8. Financial Barriers Matter – And We Need Creative Solutions

- Propofol adds greatly to the cost of the colonoscopy. Lower cost options help and are being used successfully in some places
- Cost of the prep matters: let's consider lower cost options
- The cost of FIT tests make a difference.
  - We need strategies for Community Health Centers to be able to afford evidence based, proven, high sensitivity FIT's

# Meta-analysis of FIT vs. Hemocult Sensa

Conclusion: **FIT is a superior option** for annual stool testing.

	<b>FIT</b>	<b>Hemocult Sensa</b>
Sensitivity:	73-89%	64-80%
Specificity:	92-95%	87-90%



# Many Patients Prefer FOBT

Diverse sample of 323 adults given detailed side-by-side description of FOBT and colonoscopy:

(DeBourcy et al. 2007)

- **53%** preferred FOBT
- Almost **half** felt very strongly about their preference



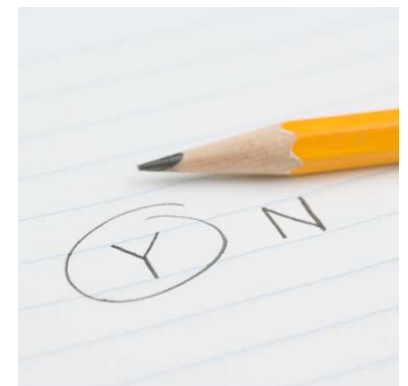
# Many Patients Prefer FOBT

Randomized clinical trial in which 997 patients in the San Francisco PH care system received different recommendations for screening:

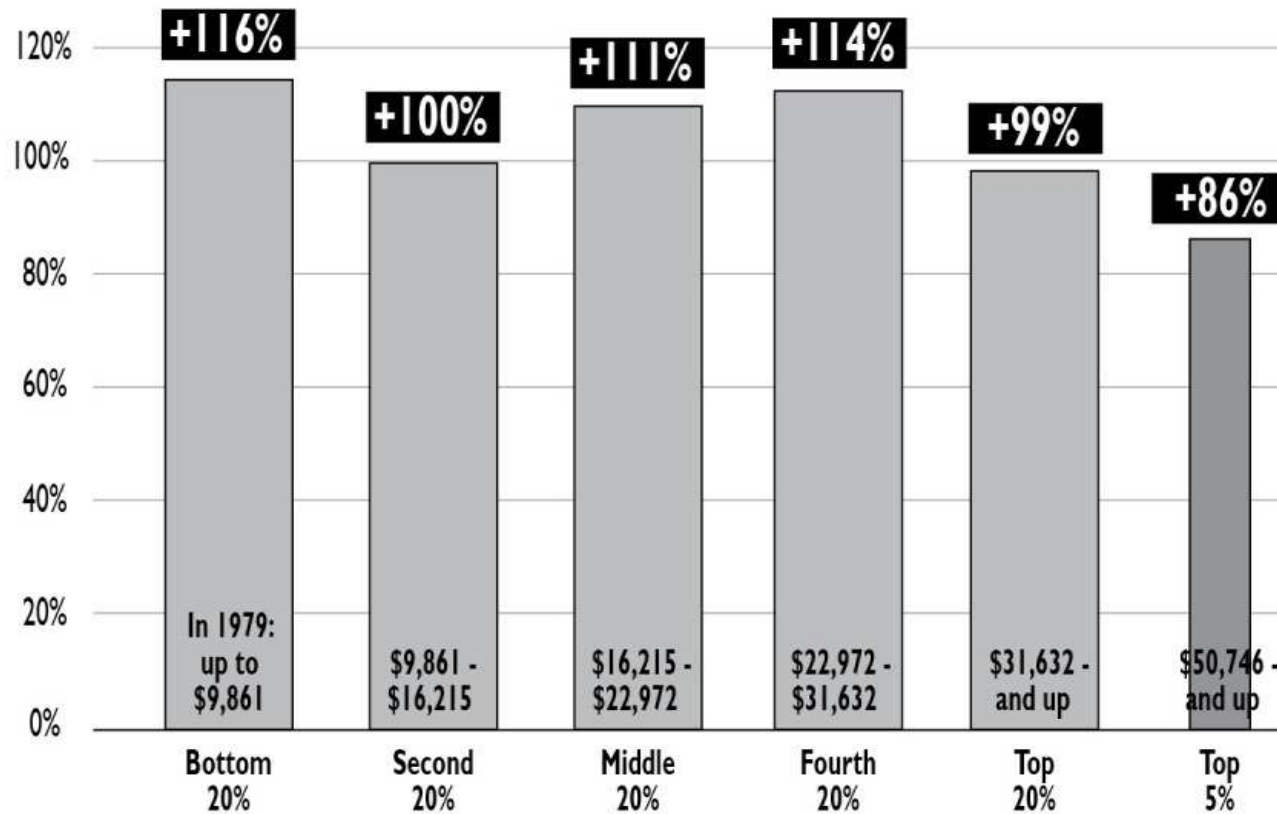
*(Inadomi et al. 2012)*

Recommended Test	Completed Screening
Colonoscopy	38%
FOBT	67%
Colonoscopy or FOBT	69%

Many patients may forgo screening **if they are not offered an alternative to colonoscopy.**



# Real Family Income Growth by Quintile & for Top 5%, 1947-1979

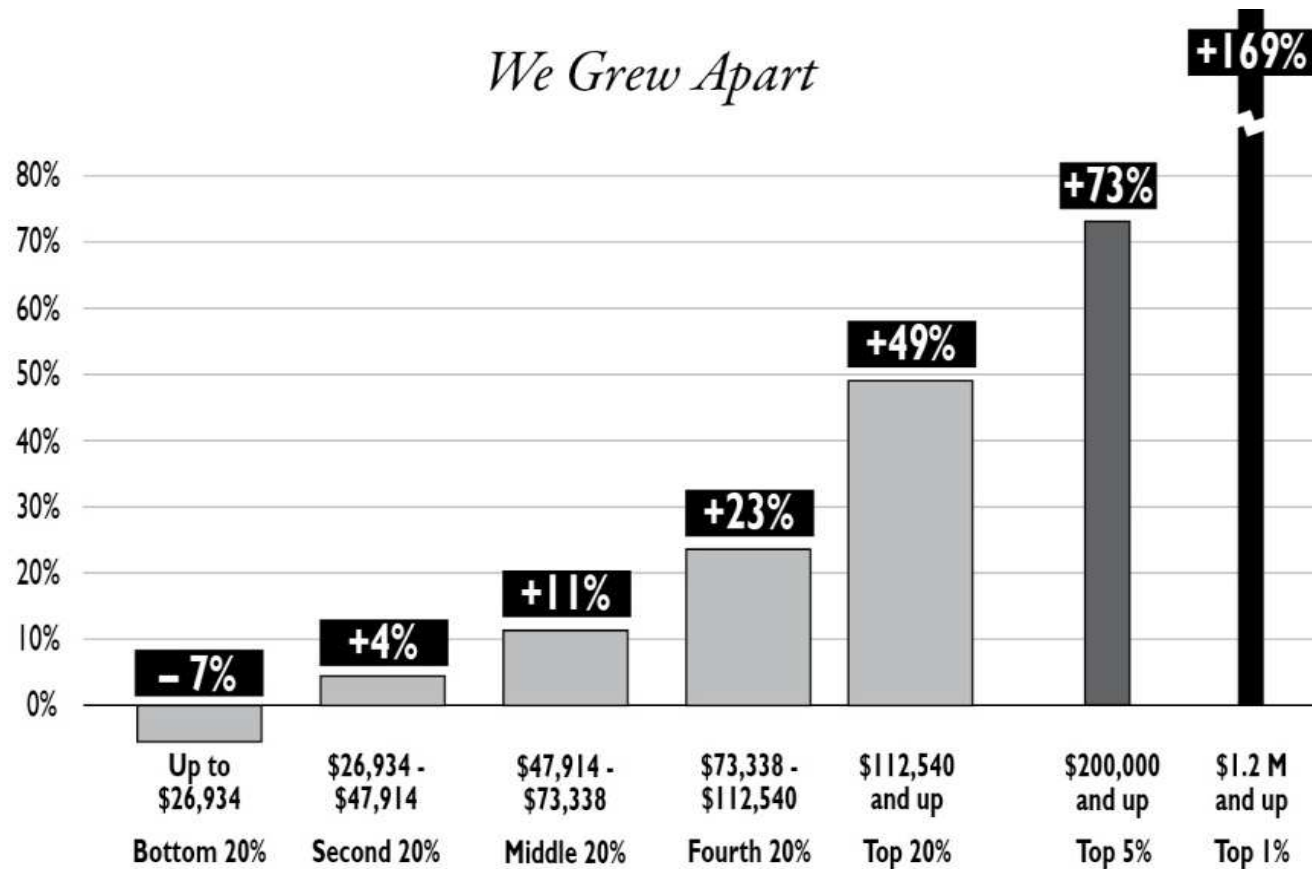


Sources: Analysis of Census Bureau data from *The State of Working America 1994-95*, Mishel, Lawrence and Bernstein, Jared, p. 37. Income ranges in 1979 dollars, from March 2000 Census Current Population Survey, Table F-1.



# Real Family Income Growth by Quintile & for Top 5% & 1%, 1979-2009

*We Grew Apart*



Source: US Census Bureau, Historical Income Tables, Tables F-1, F-3 <<http://www.census.gov/hhes/www/income/data/historical/families/index.html>>. Data for the Top 1% from Emmanuel Saez. <<http://elsa.berkeley.edu/~saez/>> is for 2008 and excludes income from capital gains.






## **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.**



## The NCCRT Member Organizations Have This Covered

- Our members have the capacity to address every one of the key strategies.
- We can design and deliver messages that matter.
- We can provide tools for primary care.
- We can build medical neighborhoods that include employers and health plans.
- We **can** do everything ... and we'll need to.

## 10. We Must Floor the Accelerator and Keep Pedal to the Metal for the Next Four Years

- We have made the commitment to increase CRC screening rates by 15% in five years ... and we only have four 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.





# We Need More Partners

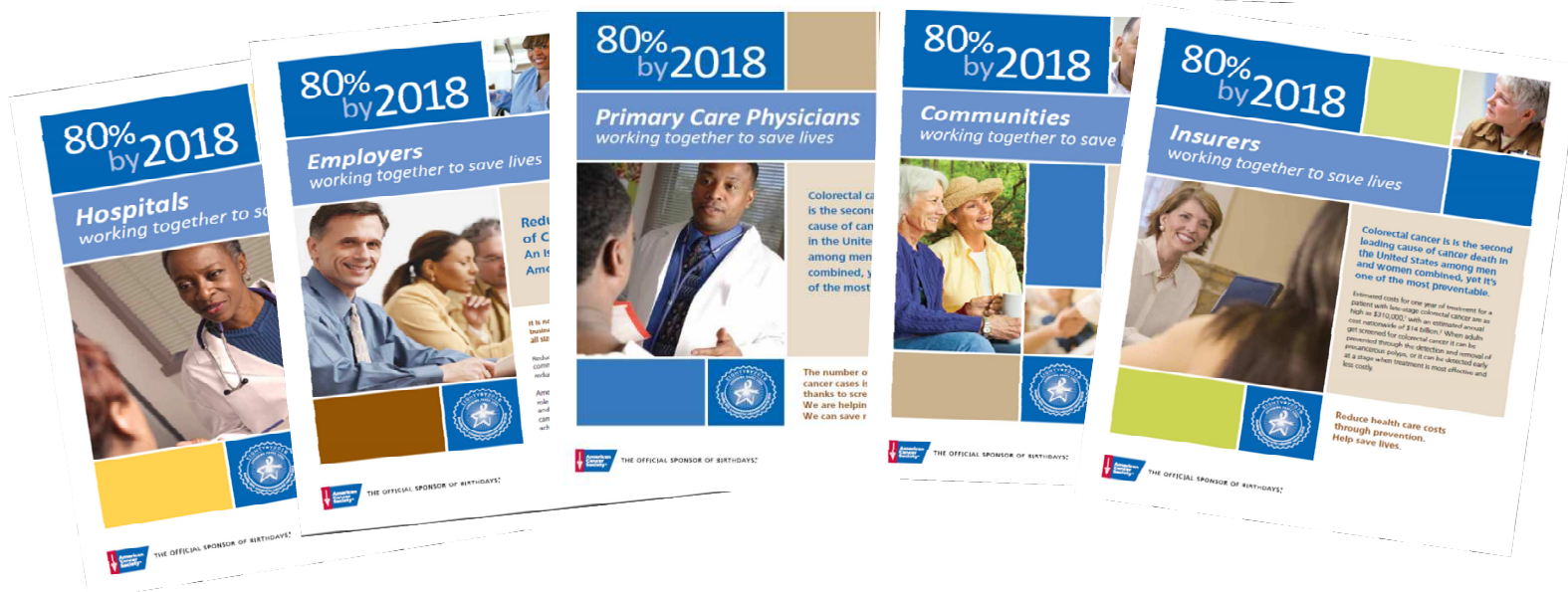
- One way to keep the momentum going is to keep enlisting new partners, creating new ways to convene, and setting more and more segmented, local goals.



# 80% by 2018 Next Steps

October:

- ☑ Roll out “So I signed the pledge, now what?”
  - Resources developed and distributed



# 80% by 2018 Next Steps

## November:

- Release 80% by 2018 tested messages
- Launch NCCRT subgroups on health plans, EMRs, CCC support recommendations
  - Meeting flashdrive offers handouts from this meeting and additional tools, including the CRC CHC manual, the 80% by 2018 packets, and the 80 by 18 pledge sheets
- Host meeting on 80% by 2018 evaluation and measurement



# 80% by 2018 Next Steps

## December

- Release 80% by 18 communications toolkit

## January and Beyond

- 2015 Policy Strategy meeting will be held
- Ratchet up NCCRT 80% by 2018 communication
  - Anticipated actions include newsletters, regular webinars, social media, and improvements to [nccrt.org](http://nccrt.org)



# The Bottom Line

In 2013, there were about 106.6 million people age 50 and older. About **61.7 million** of them are up-to-date with colon cancer screenings.

To achieve the 80% by 2018 goal *today*,  
an additional **23.5 million** people would  
need to get screened.



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By 2018, there will be 115.8 people age 50 and older.

If the 61.7 million people who are up-to-date with screening in 2013 remain adherent,

an **additional 30 million** people will need to be screened to achieve 80%.





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



### Colon Cancer Catching it early

Despite substantial decreases in colon cancer death rates over the past two decades, it remains the third-deadliest cancer in the United States among both men and women. Routine screening can prevent



80% reduction in deaths

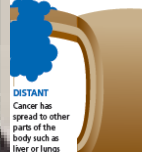
save lives

Colon lead the and one

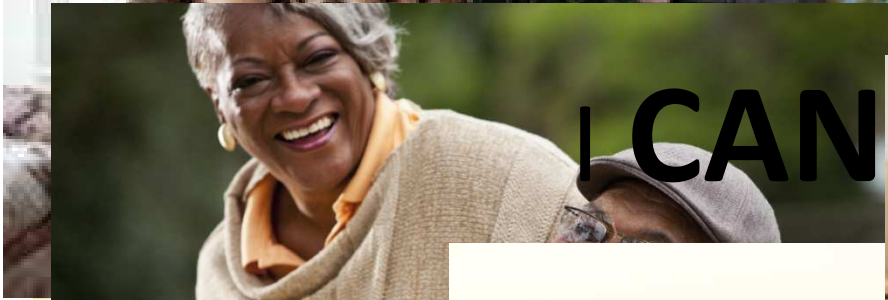
Estimated patient high cost genetic prevention as well as less of

Red

40% DIAGNOSED AT AN EARLY STAGE PARTLY DUE TO LOW SCREENING RATE



DISTANT Cancer has spread to other parts of the body such as liver or lungs



# I CAN see it!

