80% by 2018

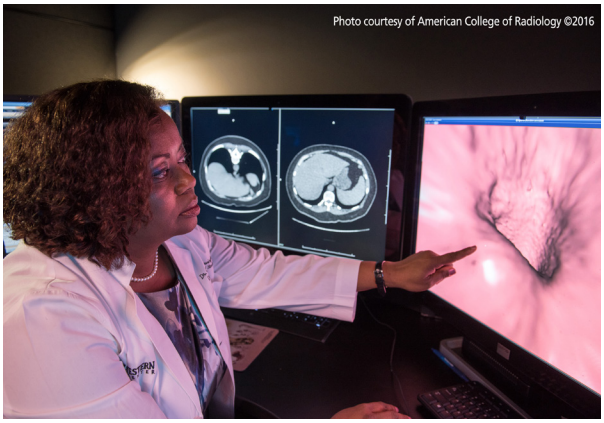
What Can Radiologists Do to Advance 80% by 2018?

Colorectal cancer is the second-leading cause of cancer-related deaths for men and women combined, yet it is largely preventable.

Join the national effort to get 80% of adults 50 years and older regularly screened by 2018.

The number of colorectal cancer cases is dropping, thanks to screening.
We are helping save lives.
We can save more.

National Colorectal Cancer Roundtable · American Cancer Society · ACR American College of Radiology · SCBT-MR Society of Computed Body Tomography & Magnetic Resonance · SAR Society of Abdominal Radiology



80% by 2018 is a National Colorectal Cancer Roundtable initiative in which more than 1,500 organizations have committed to reducing colorectal cancer as a major public health problem. Organizations are working toward the shared goal of 80% of adults ages 50 and older being regularly screened for colorectal cancer by 2018. The American College of Radiology (ACR), the Society of Abdominal Radiology (SAR) and the Society of Computed Body Tomography and Magnetic Resonance (SCBT-MR) are proud supporters of this effort.

If we can achieve 80% by 2018, 277,000 cases and 203,000 colorectal cancer deaths would be prevented by 2030.[1]

As a radiologist, here are six things that you can do to support 80% by 2018:

1. **Understand the impact of colorectal cancer and the recommended screening options, including CT colonography (CTC).**
   - Colorectal cancer is the second-leading cause of cancer death in the U.S. when men and women are combined and a cause of considerable suffering among more than 135,000 adults diagnosed with colorectal cancer each year.
   - Colorectal cancer incidence and mortality rates have dropped by over 30% in the U.S. among adults ages 50 and older in the last 15 years, with a substantial fraction of these declines likely due to screening. However, about 1 in 3 adults between 50 and 75 years old – about 23 million people – are not getting screened as recommended.
   - Populations less likely to get screened are Hispanics, American Indians or Alaska Natives, rural populations, those 50 to 64 years of age, the uninsured, and those with lower education and income.
   - The 2016 U.S. Preventive Services Task Force (USPSTF) recommendations for colorectal cancer screening in average-risk adults between the ages of 50 and 75 now include CTC every five years among a list of seven recommended screening strategies.[2] The American Cancer Society also includes CTC every five years among its list of recommended screening modalities for average-risk adults beginning at age 50.[3]

2. Understand CTC test characteristics and why some patients might prefer it over other screening tests.

- CTC represents a minimally invasive screening examination of the entire colon and rectum. Large screening trials in average-risk patients have shown CTC has very high sensitivity to detect ≥ 10 mm polyps and cancer.[4,5,6]
- Targeted patient cohorts are average-risk patients, patients at risk to undergo colonoscopy, and patients with history of prior incomplete colonoscopy.
- CTC still requires a liquid diet, with bowel catharsis and stool tagging the day before the study. However, benefits include:
  - Short examination time, typically 10 minutes or less
  - No anesthesia or recovery time
  - Well tolerated by most patients
  - Safe test profile with low complication rates[7,8,9]
  - Ability for patients to drive themselves to and from the examination
  - Ability for patients to return to work the same day if desired
- Studies have shown that patients have high patient preference ratings following CTC.[10,11,12] These benefits give hope that CTC has the potential to increase the number of patients that get screened for colorectal cancer.

3. Develop radiologist champions in your practice locally, regionally and nationally.

- Clinical champions are essential to provide local leadership to engage referring physicians and patients, collaborate with gastroenterology, and help implement clinical service lines with high-quality standards.

- As a trusted practitioner in the community, you can bring legitimacy and credibility to state or local efforts to mobilize partners to get more adults screened. Get involved with your state cancer coalition[13] or colorectal cancer roundtable to advance screening in your community. Contact your local American Cancer Society[14] office or your local or state health department to learn about activities in your state. Physician leaders and champions can speak "doctor to doctor," and often will be effective in opening doors for coalition efforts.
- Volunteer to speak out for colorectal cancer screening on local or national radio or TV or submit an op-ed to your local newspaper. If you need slides, handouts, educational materials or videos to help you speak at events, be sure to visit:
  - acr.org/Quality-Safety/Resources/CTC-Resources
  - cancer.org/colon
  - nccrt.org/tools/80-percent-by-2018
  - cdc.gov/cancer/dcpc/publications/index.htm
- Consider working with your local community health centers to improve the continuum of care for underserved patients.
- If you are championing colorectal cancer screening at your organization, pledge your organization's support for the 80% by 2018[15] initiative and consider applying for National Colorectal Cancer Roundtable membership.[16]

4. Develop a center of excellence to provide high quality CTC clinical service.

- The American College of Radiology (ACR) practice guidelines outline the essential components of patient selection, indications and contraindications, optimal bowel preparation, low-dose CTC technique, structured reporting of results with the CT Colonography Reporting and Data System (C-RADS), and training requirements, including spectrum of lesion morphologies and quality metrics.[17]
- Develop strong working relationships with endoscopists to provide same-day colonoscopy for patients with positive CTC examinations, as well as same-day CTC for incomplete colonoscopy.
- Hands-on workstation training of 50 cases with colonoscopy/pathological validation for initial competency can be obtained at multiple sites, including the ACR national training center in Reston, Virginia, national society meetings such as those held by the Society of Abdominal Radiology (SAR) and the Society of Computed Body Tomography and Magnetic Resonance (SCBT-MR) and several university practices.
- Continued maintenance of certification can be obtained at the SAR, SCBT-MR, and Radiological Society of North America (RSNA) meetings, along with correlation of CTC studies locally with colonoscopy results.
- Participate in the ACR National Radiology Data Registry (NRDR)[18] for CTC, which is a qualified clinical data registry (QCDR). This helps track three main process metrics and three outcome metrics for clinical cases performed at individual sites.[17] In time, this may be linked to pay for performance.

5. Make sure referring clinicians and your staff understand that CTC screening is recommended for individuals at average risk of developing colorectal cancer.

- Share the most recent research and clinical guidelines for colorectal cancer screening and surveillance and put processes in place to ensure appropriate risk-based screening recommendations for patients.
- Work with your staff to collect family and personal history, and recommend screening for increased- or high-risk patients at the appropriate earlier or more frequent intervals.
- Help ensure patients understand the importance of communicating their history of polyps or cancer to their immediate family members.

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6. Understand current and evolving health care policy and reimbursement decisions for CTC.

- In 2008, the American Cancer Society, along with the GI Multi-disciplinary consortium and American College of Radiology endorsed CTC for screening in average-risk patients, with surveillance at five-year intervals for negative examinations.[19]
- As of April 2017, the nation's top five health insurers—Aetna, Anthem/Wellpoint, Cigna, Healthcare Services Corporation and UnitedHealthcare—cover CTC screening without patient copay.[20] The American College of Radiology provides local coverage listings.[17]
- The 2016 USPSTF recommendations for colorectal cancer screening include CTC as a recommended screening strategy.[2] Colorectal cancer screening received an "A" grade from the USPSTF in 2016, which means the recommended tests should be provided to privately insured patients with no cost sharing under the Affordable Care Act.
- Following the 2016 USPSTF recommendation, the Healthcare Effectiveness Data and Information Set (HEDIS) measure for colorectal cancer screening was updated to include CTC in 2017.[21]
- Medicare local coverage decisions have reimbursed for CTC diagnostic cases, largely for patients after incomplete colonoscopy or at risk to undergo colonoscopy, in 48 out of 50 states since 2007.[22]
- The American Medical Association determined three CPT codes for CTC, effective in January 2010: CTC screening (74263), CTC diagnostic without contrast (74261), and CTC diagnostic with contrast (74262).
- Ensure that patients are aware that if polyps 6 mm or greater are found at CTC, patients will be recommended to undergo colonoscopy for polypectomy, unless contraindicated. Patients may be responsible for cost sharing for this follow-up examination. In average-risk patients, referral rates for colonoscopy range from 8% for patients 50 years and older[23] to 15% for patients 65 years and older.[24]

CT Colonography (CTC) in Practice: Case Studies from the Field

The University of Wisconsin Hospital and Clinics

The radiology team at the University of Wisconsin Hospital and Clinics (UWHC) is considered by many to be the nation's leading site for CTC clinical practice and research. UWHC was the first private institution in the United States to obtain third-party payor coverage for CTC.[25] Since 2004, more than 10,000 CTC examinations have been performed.[26] From 2005-2010, CTC accounted for approximately 10% of colorectal screening exams performed at UWHC.[25]

Key elements/results:

- UWHC's program was developed as a one-stop-shop, where patients are given the option of same-day colonoscopy to avoid a second bowel preparation if results are positive for a polyp 6 mm or greater. Patients leave after the exam and are told not to eat solid food for two hours until they are called with their results.
- Reasons given why UWHC patients opted for CTC include less invasive test, lack of sedation and recovery time, quick and safe procedure with ability to return to work, and no driver needed to and from the test.[11]

The National Naval Medical Center

From 2005 to 2014, more than 10,000 CTC examinations were performed through the Colon Health Initiative—the largest CTC screening program during this time—at the former National Naval Medical Center (NNMC), now the Walter Reed National Military Medical Center. An integrated model of resource sharing and clinical communication between gastroenterology and radiology was implemented to provide the clinical service of colorectal screening as well as to perform important clinical research in the evolving field of CTC. In 2010, President Obama successfully underwent CTC through this program with the benefit of avoiding conscious sedation.

Key elements/results:

- Patients were triaged into CTC versus colonoscopy, depending on clinical and family history.
- Patients with polyps 6 mm or greater were offered same-day colonoscopy. The test positive (colonoscopy referral rate) was 14-15%, for both patient cohorts < 65 years old and cohorts > 65 years old.
- More than 90% of patients who tested positive at CTC opted to undergo same-day colonoscopy, avoiding the need to undergo a second bowel preparation.
- By offering the option of CTC screening to the enrolled military population, CRC screening rates reached as high as 84% at NNMC.[27]

You have the power to have a huge impact on screening rates in your community!

Visit **nccrt.org/about/provider-education** or **cancer.org/colonmd** to learn more about how to act on the preceding recommendations and be part of 80% by 2018.

Sources

1. Meester RG, et al. Public health impact of achieving 80% colorectal cancer screening rates in the United States by 2018. Cancer. 2015 Mar 12. doi: 10.1002/cncr.29336.
2. uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/colorectal-cancer-screening2
3. cancer.org/cancer/colonandrectumcancer/moreinformation/colonandrectumcancerearlydetection/colorectal-cancer-early-detection-acs-recommendations
4. Mulhall BP, Veerappan GR, Jackson JL. Meta-analysis: computed tomographic colonography. Ann Intern Med 2005;142:635-650.
5. Halligan S, Altman DG, Taylor SA, et al. CT colonography in the detection of colorectal polyps and cancer: systematic review, meta-analysis, and proposed minimum data set for study level reporting. Radiology 2005;237:893-904.
6. Pickhardt PJ, Hassan C, Halligan S, Marmo R. Colorectal cancer: CT colonography and colonoscopy for detection- systematic review and meta-analysis. Radiology 2011; 259:393-405.
7. Pickhardt PJ. The incidence of colonic perforation at CT colonography: review of the existing data and the implications for screening of asymptomatic adults. Radiology 2006;239:313-316.
8. Sosna J, Blachar A, Amitai M, et al. Colonic Perforation at CT Colonography: assessment of risk in a multi-center large cohort. Radiology 239:457-463.
9. Burling D, Halligan S, Slater A, Noakes M, Taylor SA. Potentially serious adverse events associated with CT colonography performed in symptomatic patients: a national survey of the UK. Radiology 2006;239:464-471.
10. Moawad FJ, Maydonovitch CL, Cullen PA, et al. CT colonography may improve colorectal cancer screening compliance. AJR 2010;195:1118-1123.
11. Pooler BD, Baumel MJ, Cash BD, et al. Screening CT colonography: multicenter survey of patient experience, preference, and potential impact on adherence. AJR;2012:198:1-6.
12. Ristvedt SL, McFarland EG, Weinstock LB, Thyssen EP. Patient preferences for CT colonography, conventional colonoscopy, and bowel preparation. Am J Gastroenterol 2003;98:578-585.
13. nccd.cdc.gov/dcpc_Programs/default.aspx?NPID=2
14. cancer.org
15. nccrt.org/pledge
16. nccrt.org/membership/
17. acr.org/Quality-Safety/Resources/CTC-Resources
18. nrdr.acr.org
19. Levin B, Lieberman DA, McFarland B, et al. Screening and Surveillance for the early detection of colorectal cancer and adenomatous polyps 2008: a joint guideline from the American Cancer Society, the US Multi-society task force on colorectal cancer, and the American College of Radiology. Ca Cancer J Clin 2008; 58:130-160.
20. acr.org/News-Publications/News/News-Articles/2017/Advocacy/20170410-Top-Five-Insurers-Comply-With-Federal-Mandate-to-Cover-CT-Colonography
21. ncqa.org/Portals/0/HEDISQM/HEDIS2017/HEDIS%202017%20Volume%202%20Technical%20Update.pdf?ver=2016-10-03-114902-317
22. Knechtges PM, McFarland BG, Keysor KJ, Duszak R, Barish MA, Carlos RC. National and local trends in CT colonography reimbursement: past, present and future. J Am College Radiol 2007:4:776-799.
23. Kim DH, Pickhardt PJ, Taylor AJ, et al. CT colonography versus colonoscopy for the detection of advanced neoplasia. N Engl J Med. 2007;357:1403-1412.
24. Kim DH, Pickhardt PJ, Hanson ME, Hinshaw JL. CT colonography: performance and program outcome measures in an older screening population. Radiology. 2010 Feb;254(2):493-500.
25. Pickhardt PJ, Taylor AJ, Kim DH et al. Screening for Colorectal Neoplasia with CT colonography: Initial experience from the 1st year of coverage by private payors. Radiology 2006;241:417-25.
26. Benson M, Pier J, Kraft S et al. Optical colonoscopy and virtual colonoscopy numbers after initiation of a CT colonography program: long term data. J Gastrointest Liver Dis 2012; 21(4):391-395.
27. Cash BD, Stamps K, McFarland EG, et al. Clinical use of CT colonography for colorectal cancer screening in military training facilities and potential impact on HEDIS measures. J Am Col Radiol 2013;10:30-36.

NATIONAL Colorectal Cancer ROUNDTABLE

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