



PRIMARY CARE STRATEGY MEETING

CATALYZING PRIMARY CARE TO INCREASE
COLORECTAL CANCER SCREENING

MEETING SUMMARY

August 12, 2022 | Washington DC

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INTRODUCTION AND OPENING REMARKS

On August 12, 2022, the National Colorectal Cancer Roundtable (NCCRT) and the American Cancer Society (ACS) convened the Primary Care Strategy Meeting: Catalyzing Primary Care to Increase Colorectal Cancer Screening meeting to identify barriers and feasible solutions for increasing colorectal cancer (CRC) screening rates. The meeting was supported by the Centers for Disease Control and Prevention (CDC) and Stand Up to Cancer and was held in the ACS Cancer Action Network office in Washington, DC.

The meeting brought together leading experts and thinkers to propose strategies for increasing the uptake of CRC screening in primary care settings. Participants included NCCRT members and partners, including clinician champions, public health professionals, and leaders from medical professional societies.

MEETING OBJECTIVES

- 1. Enhance Partner Engagement:** To identify and strengthen opportunities to engage, partner, and support national primary care professional societies, state-level primary care associations, and other national groups to assist in the prioritization of increasing CRC screening rates in primary care settings.
- 2. Recognize Barriers & Needs:** To understand individual primary care clinician barriers, needs, and priorities related to CRC screening, especially those of independent primary care clinics.
- 3. Disseminate Relevant Resources:** To summarize and review current and upcoming tools from NCCRT aimed to support primary care audiences and explore where to expand or improve delivery approach/ channels of training and resources to reach individual primary care clinicians, especially independent primary care clinicians.
- 4. Understand Our Role:** To define the role national organizations, such as ACS, NCCRT, CDC, can play to stimulate the uptake of CRC screening in primary care settings.

DESIRED MEETING OUTCOMES

- 1. Know what primary care wants/needs:** NCCRT and partners will better understand the needs, wants and challenges of primary care clinicians and those working in primary care settings, and how this relates to prioritizing CRC screening among patients.
- 2. Pinpoint opportunities:** Identify future collaborative opportunities among NCCRT members and primary care organizations and societies.
- 3. Capitalize on momentum:** Develop strategies to better support primary care clinicians through dissemination of resources, information sharing, and integration of key leaders into NCCRT Strategic Priority Teams (SPT).

The meeting presentations helped familiarize participants to the current state of screening in primary care settings, showcased successes in advancing CRC screening despite ongoing challenges in primary care settings, shared the current set of NCCRT resources available to support primary care, and presented an example of the successful partnership between NCCRT and the American Association of Medical Assistants (AAMA).

The meeting was timely because it capitalized on the release of the updated NCCRT signature resource, **[Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Primary Care Practices](#)**.

OPENING REMARKS

Steven Itkowitz, MD, FACP, FACG, AGAF, Gastroenterologist and Professor, Icahn School of Medicine at Mount Sinai; NCCRT Chair

opened the meeting by acknowledging the critical role of primary care in improving CRC rates. He highlighted the 80% in Every Community campaign and the many useful resources NCCRT has provided to its members and their networks.

He recognized that the meeting participants came from many different fields but shared a common goal of increasing CRC screening rates by working together in partnership.

He encouraged participants to let the NCCRT know how NCCRT could help them to increase CRC screening rates in their communities.

Dr. Itkowitz closed by reminding the audience of the three NCCRT priority areas:

1. On-time CRC screening as soon as one is eligible, whether at an average or increased risk for CRC cancer
2. Ensuring timely colonoscopy following an abnormal, non-colonoscopy screening test
3. Understanding and addressing racial barriers and disparities

CRC SCREENING IN PRIMARY CARE

RICHARD C. WENDER, MD, CHAIR OF FAMILY MEDICINE AND COMMUNITY HEALTH, PERELMAN SCHOOL OF MEDICINE, UNIVERSITY OF PENNSYLVANIA; NCCRT CHAIR EMERITUS

Primary care is a public good, and access to primary care improves overall population health.

Primary care physicians provide most primary care visits, but this number is steadily declining. The rise of visits to other clinicians, including nurse practitioners and physician assistants, has been increasing rapidly. (Please reference the [slide deck](#) for citations.)

- About 50% of primary care physicians own their own practice.
- The percentage of Black or African American primary care physicians has remained stable over recent years.

RECENT NATIONAL UPDATES

- The **ACS** (2018) and the **United States Preventive Services Task Force** (2021) now recommend CRC screening begins at age 45 for both men and women at average risk.
- The **President's Cancer Panel report** strongly endorsed the national roundtable model.

THERE IS AN ENORMOUS RANGE IN THE AVAILABILITY OF PRIMARY CARE PHYSICIANS AMONG STATES

- The number of primary care physicians per 100,000 people varies among states.
- Mississippi has less than 50, and Washington, DC, has 122.8.
- Each increase of 10 primary care physicians/100,000 is associated with an increase of 51.5 days in average lifespan.

Primary care physicians are feeling stressed, and about 42% of them reported that they are burned out. Primary causes include:

- Too many bureaucratic tasks
- Too many hours at work
- Too many difficult patients
- Feeling like a cog in the machine
- Lower-than-expected earnings

Surveys indicated that possible solutions were better training for staff members, fully staffed clinics, more vacation time, training on how to better utilize electronic health record (EHR) system, and smaller patient volumes.

QUESTIONS AND ANSWERS

Q1. Do you have additional information regarding why family physicians are least satisfied and would not go into family medicine again? Does it have to do with pay?

A1. I think it's more burnout because all people going into primary care know that they have decided on what they are going to earn.

Comment. The screening conversation can also lead to an opportunity to discuss reducing CRC risk. For example, when clinicians discuss screening with patients, some patients directly ask, "What can I do to reduce my risk of CRC?"

IMPROVING CRC SCREENING RATES

NEW ORLEANS EAST LOUISIANA COMMUNITY HEALTH CENTER (NOELA)

*KEITH WINFREY, MD, MPH, FACP,
CHIEF MEDICAL OFFICER, NOELA*

NOELA won the NCCRT's Grand Prize 80% by 2018 National Achievement Award in 2019 for increasing their CRC screening rates from 11% in 2012 to 80% in 2018.

The population served by NOELA had many barriers:

- CRC screening was not a priority
- Lack of awareness about screening options
- Lack of motivation to screen and receive colonoscopy following an abnormal screening test
- Lack of reliable transportation

From an organizational perspective, barriers included:

- Lack of strong clinician recommendations
- Lack of a CRC screening and cancer registry
- Lack of colonoscopy capacity at the hospital (at the time, confirmation of colonoscopy referral requests could take an entire year)

NOELA WON NCCRT'S GRAND PRIZE 80% BY 2018 NATIONAL ACHIEVEMENT AWARD IN 2019

The NOELA Community Health Center is a nationally recognized Patient-Centered Medical Home that provides comprehensive primary and preventive health care services to the underserved communities in and around the New Orleans East Louisiana area.

NOELA initially thought increasing screening rates would be straightforward.

NOELA originally thought that increasing rates would be straightforward, that showing clinicians the data would be sufficient, that clinicians would always give consistent recommendations without bias, and that providing stool tests would increase screening rates. However, this was not the case.

NOELA partnered with the NCCRT to implement steps to increase their screening rates.

The ACS approached NOELA about partnering to increase CRC screening rates. After working with ACS staff and utilizing the NCCRT Steps Guide, NOELA's CRC screening rates began to improve significantly.

NOELA learned several lessons in their journey, from 11% to 80% CRC screening rates.

Implementing individual evidence-based interventions one at a time did not increase screening rates as much as they expected. Instead, they found that using multiple interventions worked better. In hindsight, NOELA also thought they set their screening rate bar too low (40% to 50%).

NOELA's advice for others is to examine assumptions, get both administrative and clinical support for new processes, set stretch goals for screening rates, and use existing resources and tools instead of reinventing the wheel.

NOELA STRATEGIES TO REACH THE 80% SCREENING RATE TARGET

- Using a fecal immunochemical test (FIT) strategy was successful for their population, even though sometimes patients received 2, 3, or 4 kits before one was completed and returned.
- Providing patient navigation was a huge success.
- Offering patients screening at every clinic visit increased uptake.
- Using patient and clinician reminders was productive.
- Patient incentives were successful.
- Offering free CRC screening kits to the uninsured helped increase rates.



QUESTIONS AND ANSWERS

Comment. Having a team champion is probably one of the most important things to do. It's not a priority if you don't have a clinical champion. Clinics could achieve an 80% screening rate if they implemented all of these lessons; in contrast, they could be at a 22% screening rate if they implemented none of them.

Q1. One of the priorities this year is colonoscopy completion after an abnormal non-colonoscopy screening test. How is that going?

A1. The follow-up rates are not as high as we'd like to see them, and we remind patients they need a colonoscopy after an abnormal FIT result. We have a dedicated navigator who tracks the time between a positive (abnormal) FIT and a colonoscopy.

Q2. The Cologuard company helps with follow-up and adherence, but you can't instruct the patients in their native language, etc. What kind of experience have you had with Cologuard?

A2. This is the first year we are putting forward Cologuard as our strategy of choice, and part of that was because we were able to secure a grant to offer Cologuard to our uninsured patients. The Cologuard workflow is different; if patients don't complete a Cologuard in time, another one is sent out. Each kit costs about \$600. That is an investment for patients who may not be ready or have uncertainty about completing a kit or not. We like that completed tests are valid for three years, which means two extra years to work on colonoscopy.

ALLEGHENY HEALTH NETWORK PREMIER MEDICAL ASSOCIATES

*FRANCIS R COLANGELO MD, MS-HQS, FACP,
DIRECTOR OF THE OUTCOMES OFFICE,
ALLEGHENY HEALTH NETWORK*

Premier Medical Associates (PMA) increased its screening rates from 57.5% to 80%.

Dr. Richard Wender gave a presentation to PMA staff, which inspired them to increase their screening rates by offering FIT kits as a screening option. In the next 15 months, PMA increased its rates from 57.5% (2012) to 75%. Then they hit a barrier of 75%, and their progress slowed down. They credit their Plan-Do-Study-Act process for moving screening rates from 75% to 80% (2015) and beyond.

PMA USED PLAN-DO-STUDY-ACT

PMA credits offering a FIT screening strategy and using a Plan-Do-Study-Act quality improvement process for increasing their CRC screening rates.

The key strategies that PMA used to improve their screening rates were:

- Clinician education and offering a menu of CRC screening options
- Transparent data reporting
- Proactive outreach to patients reaching screening age
- Automated robocall reminders
- Test completion tracking with a FIT registry and an abnormal FIT result registry

Top-level support for the CRC screening improvement program was critical.

When PMA first began transparent data reporting of screening rates, some clinicians protested, but with leadership support for transparency, all clinicians were eventually on board.

PMA created infrastructure and processes to support a FIT screening strategy.

PMA created a registry of regular FIT patients and sent out new FIT kits on the 11-month anniversary of the previous test. 90% of those patients returned the kits within two weeks. Every Monday, a report is created and distributed of patients who had positive (abnormal) FIT results in the previous week.

PMA changed its patient messaging for patients with abnormal FIT results.

Patient messaging now says, “I will agree to allow you to be screened with a FIT test if you promise me that you will do a colonoscopy if the test result is positive.” About 85% of the PMA patients with positive FITs receive that scripting and complete follow-up colonoscopies; letters are sent out if patients have not scheduled a follow-up within 30 days.

PMA addressed screening disparities between Black and white patients.

In June of 2021, PMA stratified their screening rates by race and ethnicity and realized there was a 9% disparity in the screening rates between Black (73%) and white (82%) patients. By focusing on the issue and using the strategies shown in the callout box, the disparity was reduced to 2% in six months.

THE PMA SUCCESS STRATEGIES

- Using a FIT strategy
- Having the commitment and support of the top-level leaders
- Changing their patient messaging
- Reviewing their screening rates by race and ethnicity to address disparities

QUESTIONS AND ANSWERS

Q1. How did you get your clinicians to change their habits of offering only colonoscopy?

A1. Dr. Richard Wender gave a presentation on the data and the benefits of offering screening choices to patients, and that helped to drive the change. Some of the key concepts were having a CRC champion; thinking about implementing three or four evidence-based interventions (EBIs) at a time; focusing on both the patient and the clinician; thinking about all the touch points where changes could make a difference; and thinking about accelerating the EBIs that were already in place.

Q2. When you look at your screening rates, do abnormal non-invasive tests count towards the screening rate if the patient has not completed a follow-up colonoscopy?

A2. Yes.

Comment. It is critical to have the data available to tell the story and share the messages.

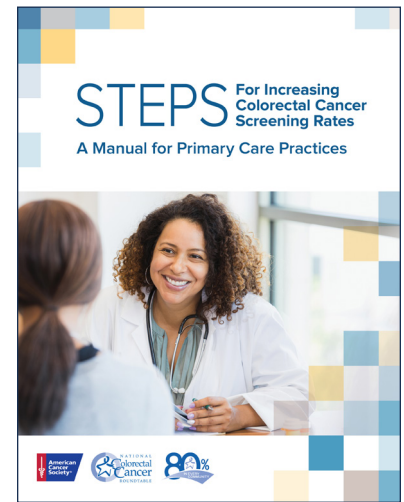
RESOURCES: NCCRT TOOLS AND RESEARCH

EMILY BELL, MPH, DIRECTOR, NCCRT - COLORECTAL CANCER INTERVENTIONS

KAITLIN SYLVESTER, MPA, DIRECTOR, NCCRT - PROGRAMS AND PARTNERSHIPS

The NCCRT supports primary care clinicians in their efforts to increase CRC screening rates by creating and disseminating helpful resources, best practices, and evidence-based interventions.

- The new and revised **Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Primary Care Practices** was released in 2022. It describes the four key steps of 1) making a plan, 2) identifying a team, 3) screening patients, and 4) coordinating care. The appendices in the guide contain more than 50 pages of templates, scripts, snapshots of example EHR reports, and letters for communicating with patients.
- One helpful tool is the Coloscopy Needs Calculator, which allows clinicians to estimate the number of colonoscopies that will be required. The number can also be useful for negotiating lower costs for higher colonoscopy volumes.



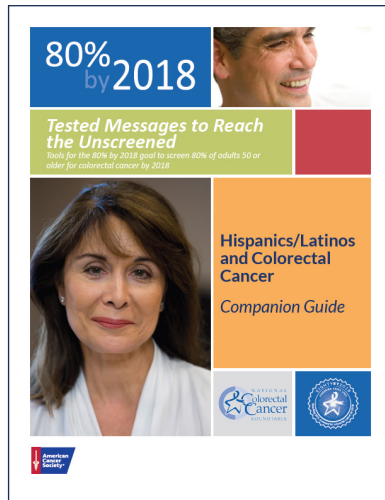
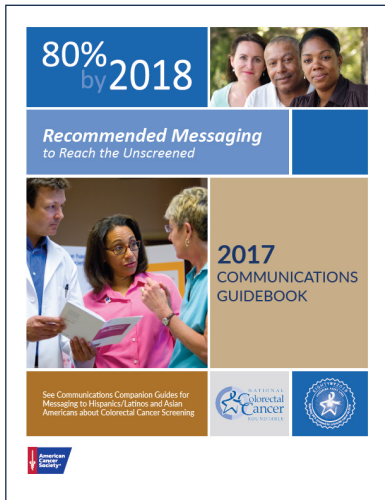
- The **NCCRT Resource Center** contains many useful clinical, communications, and advocacy resources for primary care clinicians and administrative staff. The tools can be selected by the target audience, healthcare setting, and resource type. The Resource Center contains NCCRT resources as well as tools created by external partners.

- The **Clinician's Reference: Stool-Based Tests for Colorectal Cancer Screening** tool encourages clinicians to offer screening options to their patients. It provides details about various stool-based tests, the efficacy of the tests, and the differences between guaiac-based fecal occult blood tests, FIT, and mt-sDNA tests. It also explains the components of a successful stool-based testing program. In one study, the highest screening rates were achieved by offering patients choices of the screening method.

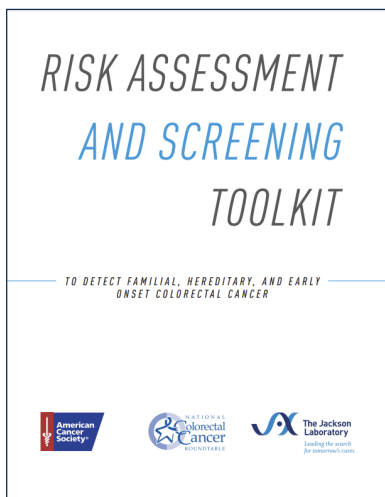
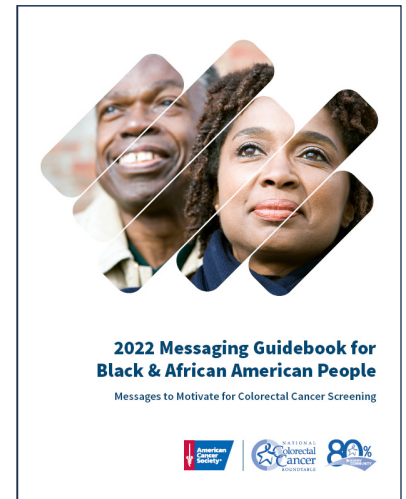
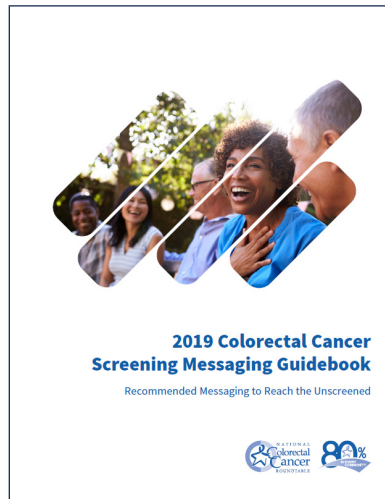


NCCRT PRIMARY CARE STRATEGY MEETING

- The NCCRT communications and messaging guides provide tested messages for CRC screening. The first communications guidebook was released as part of the 80% by 2018 campaign and was followed by two companion guides (in 2015 and 2016) that provided recommended messaging and strategies to reach **Hispanic/Latino** and **Asian** populations.



- In 2019, the NCCRT published a new **CRC Screening Messaging Guidebook** containing messages to reach the unscreened. And in 2022, a new messaging guidebook was published to highlight the most effective messages to motivate **Black and African American** people to get screened for CRC. Market research and messaging guidance is in development on strategies for reaching the soon-to-be and newly-eligible for CRC screening.



- The NCCRT's **Risk Assessment and Screening Toolkit** targets primary care clinicians with instructions for implementing risk assessment and collecting family history. It explains the importance of diagnostic testing for symptomatic patients under 45 years old, emphasizes awareness of early-onset CRC, and contains useful and actionable tools.

QUESTIONS AND ANSWERS

Comment. We had a tremendous improvement in the disparity rate in our practice after using the message from the guidebook, “Did you know that colon cancer is the second leading cause of cancer death in Black and African American people in the United States?”

Q1. What has been done differently for the age 45-49 population, given the new ACS and USPSTF guidelines?

A1. Our two recent market research studies focused on ages 45 and older. In 2019, a focus group was held for the 45+ population to create a baseline for later comparisons.

Q2. Have you conducted formal outreach to state roundtables?

A2. No, not formal outreach. The NCCRT works with partners in different regions and states and hopes to do more outreach to state and regional coalition groups, roundtables, and communities.

PARTNERSHIPS TO IMPROVE CRC SCREENING RATES

*DONALD BALASA, JD, MBA, CEO,
LEGAL COUNSEL*

The American Association of Medical Assistants represents 90,000 medical assistants throughout the United States and offers a Certified Medical Assistant training designation to its members. Medical assistants work in outpatient settings and do both front-office and clinical tasks. About 60% of the AAMA-certified medical assistants (CMAs) work in primary care settings. The AAMA staff began talking about partnering with the NCCRT in 2018.

AAMA partnered with NCCRT to provide CRC screening materials.

AAMA worked with NCCRT to empower medical assistants to be more effective advocates for CRC screening by providing them with CRC screening messages to reach patients more easily. Medical assistants are helpful for CRC screening because they are communication intermediaries between clinicians and patients.

AAMA partnered with NCCRT to provide continuing education on CRC screening.

The AAMA promoted its CRC education initiative through a new course titled Medical Assistants’ Roles in Improving Colorectal Cancer Screening Rates: Getting to 80% by Durado Brooks, MD, MPH, former vice president of cancer control interventions at ACS. This course was marketed by e-blasts and social media posts throughout the year, and the price of the course was discounted during National Colorectal Cancer Awareness Month and Medical Assistants Recognition Week. About 5,000 AAMA members have taken the course for continuing education unit credits.



AAMA partnered with NCCRT to amplify CRC screening messages.

Another partnership strategy was to combine CRC Awareness Month with Medical Assistants Recognition week, which put the spotlight on CRC screening in a new way. The AAMA used social media to announce its partnership with the NCCRT and achieved a significant number of message impressions. Many of the AAMA state societies created their own messaging programs and tailored them to their local circumstances. The AAMA was also able to use some of the NCCRT materials and provide some in-service training for staff.

QUESTIONS AND ANSWERS

- Q1.** Were the medical assistants ever given patient education materials or patient guides to help with that discussion, and did they find them helpful? Do you know if there was a certain type of aid that they felt was the most helpful?
- A1.** They were given materials, and they did find them helpful. No formal survey has been done to identify the most helpful resources.
- Q2.** Do you know if there's been an uptake in screening among the medical assistants themselves based on this program?
- A2.** Anecdotally, we have been told that, yes, there has been an increase. We have not quantified that yet. I also wrote an article summarizing about six different studies showing how medical assistants have been effective in increasing the rates of CRC screening.
- Q3.** In a study with the CDC, standing orders for immunizations were created so that clinical staff could give the immunizations without requiring a physician to order them.
- A3.** Yes, standing orders are generally acceptable, although the rules vary among states.



BARRIERS AND SOLUTIONS

Participants in the breakout groups were asked to identify barriers and solutions around the following three questions:



What do you recommend for helping overcome challenges in promoting colorectal cancer screening in primary care?



Which essential partners should be working towards these solutions?



How should these partners collaborate?



This section describes the barriers, solutions, and partners identified by the breakout groups.

BREAKOUT GROUP 1: CLINICIAN KNOWLEDGE, PRECONCEIVED NOTIONS, IMPLICIT BIAS



BARRIERS

- Clinician preference for colonoscopy
- Clinician implicit bias about patients
- Preconceived notions about CRC screening
- Limited time/capacity and competing priorities



SOLUTIONS

- Require implicit bias training for clinicians
- Educate clinicians on the value of offering the menu of CRC screening test options
- Engage professional societies to educate member networks on the importance of CRC screening and providing options
- Additional solution: Engage professional societies in aligning/national endorsement goals/data metrics
- Integrate education into medical residency training
- Modernize NCCRT tools (point of care) to make it easy for clinicians to use and learn (e.g., videos, QR codes, apps) (6 votes)
- PT focused: Use innovative channels to reach patients (e.g., QR codes in waiting rooms)



DISCUSSION

Clinicians must unlearn that colonoscopy is the gold standard. In clinician education, there is a nuanced message about not offering too much choice and tailoring the choices that are available to the medical community. Options will differ by medical setting.

BREAKOUT GROUP 2: PRACTICE STRUCTURE NOT SET UP FOR PATIENT-CENTERED CRC SCREENING



BARRIERS

- Colonoscopy access for Medicaid/uninsured rural populations
- The payment model is weakly linked to quality outcomes
- Lack of patient navigation services
- System readiness for population screening
- All clinic staff not engaged in the process
- Lack of shared decision-making



SOLUTIONS

- Pull together and present case studies on how to present ROI to executive leadership
- Increase communication and collaboration between primary care and GI clinicians
- Project ECHO Primary Care and GI, Links of Care
- Define the role of individuals in the practice
- Define the process for each screening modality (QR code in the waiting room, brief handout to read while waiting for the clinician, share practice successes, frameworks, and examples to share where team-based care is successful in increasing CRC screening)
- Create systems to identify who is overdue for screening
- Incorporate patient navigation throughout the CRC continuum
- Expand opportunities for external and internal resources



DISCUSSION

Key steps are to define the roles of individuals and create new systems. It is likely that many future visits will be virtual. There is an opportunity to screen for other illnesses when screening for CRC. Women's health does a good job of bundling care.

The skills developed in CRC screening translate to other things. It helps develop the capacity to do population management out of an EHR feature that was developed from billing. This requires commitment from the CEO.

BREAKOUT GROUP 3: PATIENT EDUCATION AND ENGAGEMENT



BARRIERS

- Patient lack of education and engagement
- Patient lack of activation or readiness
- Patient lack of awareness about the need to start screening
- Patient limited knowledge/preconceived notions
- Lack of shared decision-making
- Not seeing the process through the eyes of the patient



SOLUTIONS

- Set up a comparison with Key Partners (CDC) for “45 is the new 50.”
- Develop educational modules about choice and screening for staff and clinicians for motivational interviews
- Sponsor a multi-channel education message to prep for on-time screening
- Utilize patient reminders in a more innovative fashion (Birthday reminders for health and wellness to personalize prevention plan/ “Next one due” screening campaign)



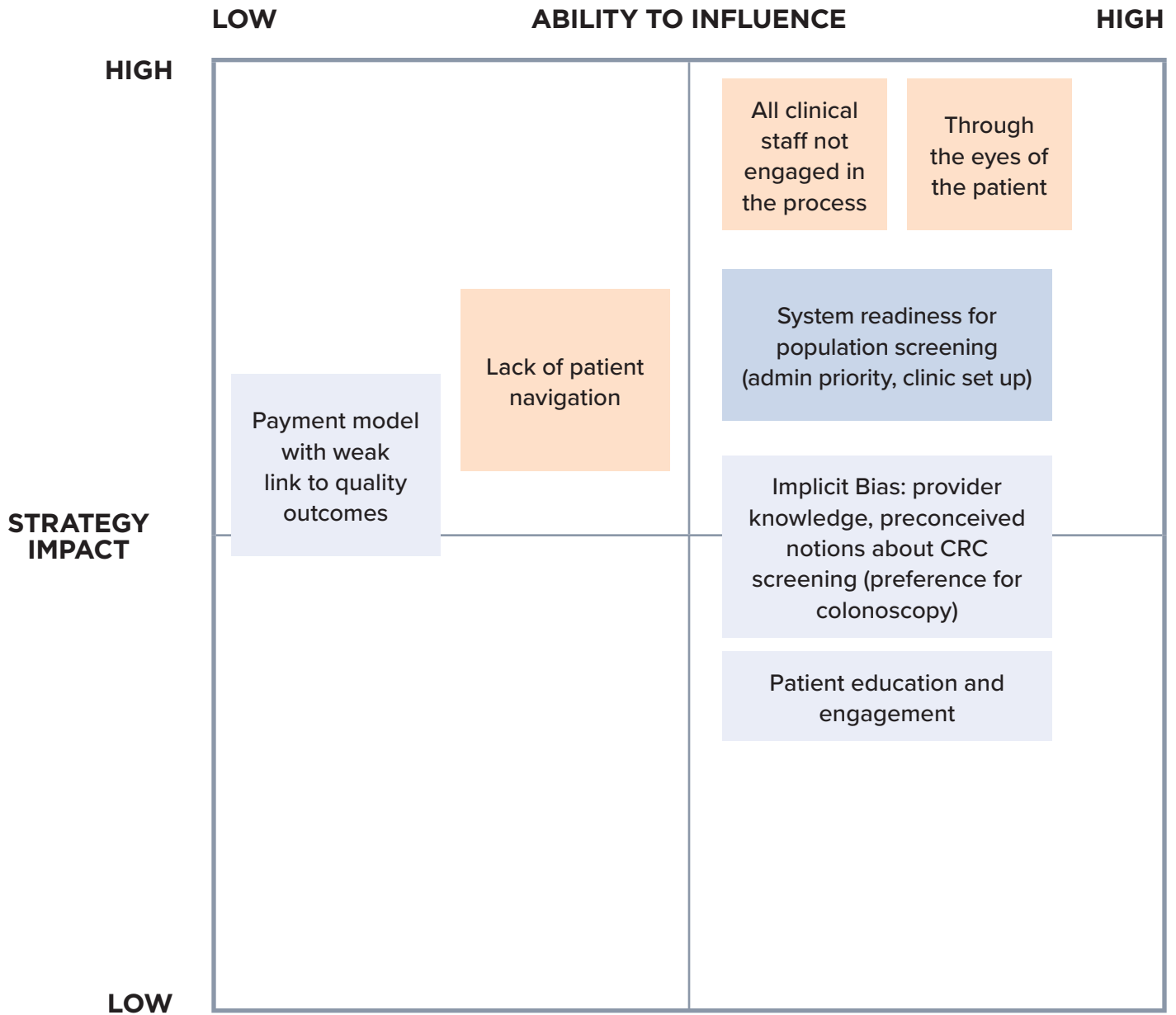
DISCUSSION

Participants discussed the success that dentists have when it comes to appointment reminders. Additionally, participants were curious about what would make these campaigns different from others. In response, presenters acknowledged that the campaigns would require a great investment of both effort and money. One option would be to find a big partner who is excited about this work. More evidence is needed to justify the expenditure.

PRIORITIZED BARRIERS

In the context of identifying solutions, participants focused on impactful strategies that they could address in some meaningful way within two to three years.

Participants prioritized their solutions using the *2 x 2 Impact x Influence Matrix* process. The 2 x 2 matrix process helps to assess (1) the potential impact of a strategy or change (low, high) on one axis and (2) the ability to influence or effect that strategy or change (low, high) on the other axis.



POTENTIAL PARTNERS

MEDICAL AND PROFESSIONAL ORGANIZATIONS

- American Academy of Family Physicians
- American Academy of Physician Assistants
- American Academy of Physician Associates
- American Association of Medical Assistants
- American Association of Medical Colleges
- American Association of Nurse Practitioners
- American College of Physicians
- American College of Preventive Medicine
- American Gastroenterological Association
- American Medical Association
- Academy of Oncology Nurse & Patient Navigators
- American Psychological Association
- American Society for Gastrointestinal Endoscopy

PUBLIC HEALTH ORGANIZATIONS

- American Cancer Society
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- National Cancer Institute

NATIONAL MEMBERSHIP ORGANIZATIONS

- Association of American Cancer Institutes
- Association of Community Cancer Centers
- Coalition of Christian Nurse Practitioners
- Medical Group Management Association
- National Association of Community Health Centers
- National Colorectal Cancer Roundtable
- National Navigation Roundtable

LOCAL COALITIONS AND ROUNDTABLES

- CDC awardees
- Cancer coalitions
- Local roundtables
- NCCRT member organizations
- CEO Roundtable - Data and Going for Gold Initiatives

CLINICS AND HEALTH SYSTEMS

- Clinical staff and leaders
- Community health workers
- Quality improvement professionals
- Federally qualified health centers
- Health systems
- NCI-designated cancer centers
- Community cancer centers

POLICY AND ADVOCACY

- Policymakers
- CRC advocacy organizations

OTHER ORGANIZATIONS

- Electronic Health Record companies
- FIT and DNA test makers
- Healthwise
- Local employers
- Payers
- Women's Preventive Services Initiative

PARTICIPANTS

Donald Balasa, JD, MBA

Chief Executive Officer and House
Legal Counsel
American Association of Medical
Assistants (AAMA)

Emily Bell, MPH

Director, Colorectal Cancer Interventions
National Colorectal Cancer Roundtable
(NCCRT)
American Cancer Society (ACS)

Garfield Clunie, MD

President-Elect
National Medical Association (NMA)

**Frank Colangelo, MD, M.S.-HQS,
FACP**

Director, Outcomes Office
Premier Medical Associates
Planning Committee Member

**Sallyann Coleman King, MD,
MSc**

Medical Director, Colorectal Cancer
Control Program, Program Services
Branch, Division of Cancer Prevention
and Control
Centers for Disease Control and
Prevention (CDC)

Nikki Hayes, MPH

Branch Chief, Comprehensive Cancer
Control Branch, Division of Cancer
Prevention and Control
National Center of Chronic Disease
Prevention and Health Promotion,
Centers for Disease Control and
Prevention (CDC)

Jim Hotz, MD, MACP

Director, Clinical Services
Albany Area Primary Health Care
National Association of Community
Health Centers (NACHC)

**Steven Itzkowitz, MD, FACP, FACG,
AGAF**

Professor of Medicine, Oncological
Sciences & Medical Education
Icahn School of Medicine, Mount Sinai
Chair, National Colorectal Cancer
Roundtable
Planning Committee Member

John Kennedy, MD

Chief Medical Officer
American Medical Group Association
(AMGA)
President, AMGA Foundation

Amelia Khalil

Team Lead, Quality Recognition &
Health Promotion
Health Resources and Services
Administration (HRSA)

**Maureen Killackey, MD, FACS,
FACOG**

American College of Obstetricians and
Gynecologists (ACOG)

Caleb Levell, MA

Strategic Director, National Partnerships
& Roundtables
American Cancer Society (ACS)

Laura Makaroff, DO

Senior Vice President, Prevention and
Early Detection
American Cancer Society (ACS)

Sawra Maurer, PA-C

Senior Manager, Advanced Practice
Providers Medical Affairs
Exact Sciences

Angela Mickalide, PhD, MCHES

Vice President, Programs and Education
American College of Preventive
Medicine (ACPM)

Kerstin Ohlander, MPH

Principal
Ohlander Consulting

Allison Rosen, MS

Director, Project ECHO
American Cancer Society (ACS)

Michael Sapienza

Chief Executive Officer
Colorectal Cancer Alliance (CC Alliance)

Sarah Shafir, MPH

Managing Director, National
Partnerships & Innovation
American Cancer Society (ACS)

Ryan Soisson

Principal
Soisson Associates

Kaitlin Sylvester, MPA

Director, Programs & Partnerships
National Colorectal Cancer Roundtable
(NCCRT)
American Cancer Society (ACS)

Annie Thibault, MS

Executive Director
Colorectal Cancer Prevention Network

Aubrey Villalobos, DrPH, Med

Health Scientist, Implementation
Science Team
National Cancer Institute (NCI)

Keith Winfrey, MD, MPH

Chief Medical Officer
New Orleans East Louisiana Community
Health Center (NOELA)

Richard Wender, MD

Chair of the Department of Family
Medicine and Community Health
Penn Medicine
Planning Committee Member

David Weinberg, MD, MSc

Chair, Department of Medicine
Fox Chase Cancer Center, Temple
Health
American College of Physicians (ACP)

Andrew Wolf, MD, FACP

Senior Professor of Medicine
University of Virginia School of Medicine
Planning Committee Member

John Wood, MD, MBA, FAAFP

Medical Director
Penn Medicine Lancaster General
Health