Lightning Round: Recent Research and Emerging Work to Guide Timely, Quality Colorectal Cancer Screening and Follow Up

11:10 AM – 12:00 PM

Lightning Round:
Recent Research and Emerging Work

Moderator
Pascale White, MD, MBA, MS, FACG
Assoc. of Black Gastroenterologists and Hepatologists

Carolyn M. Rutter, PhD
Fred Hutch Cancer Center

Alyson Moadel-Robblee, PhD
Albert Einstein College of Medicine

Anjee Davis, MPPA
Fight Colorectal Cancer

Cost effectiveness of blood tests to screen for colorectal cancer: Impact of adherence

Carolyn Rutter, PhD
Professor, Hutchinson Institute for Cancer Outcomes Research (HICOR)
& Biostatstistics, Public Health Scienes

September 27, 2024

Conflict of Interest

No conflicts of interest

Funding statement

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- **Grant U01-CA253913**: the Cancer Intervention and Surveillance Modeling Network (CISNET).
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The views expressed are my own and not necessarily those of Fred Hutch or the National Institutes of Health

National Coverage Analysis (NCA) | Decision Memo

1/19/2021

Screening for Colorectal Cancer - Blood-Based Biomarker Tests

CAG-00454N

Expand All | Collapse All

Decision Summary

The Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is sufficient to cover a blood-based biomarker test as an appropriate colorectal cancer screening test once every 3 years for Medicare beneficiaries when performed in a Clinical Laboratory Improvement Act (CLIA)-certified laboratory, when ordered by a treating physician and when all of the following requirements are met:

https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&NCAId=299

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The evidence is sufficient to cover a blood-based test every 3 years

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Decision Summary

The patient is:

- age 50-85 years, and,
- asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test), and,
- at average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis; no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

Covered for screening average risk patients 50-85

National Coverage Analysis (NCA) | Decision Memo

1/19/2021

Screening for Colorectal Cancer - Blood-Based Biomarker Tests

CAG-00454N

Expand All | Collapse All

Decision Summary

The blood-based biomarker screening test must have all of the following:

- FDA market authorization with an indication for colorectal cancer screening; and
- proven test performance characteristics for a blood-based screening test with both sensitivity greater than or equal to 74% and specificity greater than or equal to 90% in the detection of colorectal cancer compared to the recognized standard (accepted as colonoscopy at this time), based on the pivotal studies included in the FDA labeling.

Test must have:

- sensitivity ≥ 74%
- specificity ≥ 90%

for detection of CRC

- FDA approval

The New York Times

By Gina Kolata

May 23, 2024

F.D.A. Panel Endorses Safety of Colon-Cancer Blood Test

The Guardant Health Shield test, one committee member said, "is better than nothing for patients who are getting nothing, but it is not better than a colonoscopy."

The New York Times

By Gina Kolata

May 23, 2024

F.D.A. Panel Endorses Safety of Colon-Cancer Blood Test

The Guardant Health Shield test, one commit
"is better than nothing for patients who are ge
is not better than a colonoscopy."

By Gina Kolata

July 29, 2024

The New York Times

F.D.A. Approves Blood Test for Colon Cancer Detection

While not a perfect alternative to colonoscopies, experts hope the test could lead to more people getting screened for colorectal cancers.

Would a blood test that satisfies CMS coverage criteria be effective and cost-effective relative to FIT?

Cost assumption:
$500 per blood test

Gastroenterology 2024;■:1–10

Effectiveness and Cost-Effectiveness of Colorectal Cancer Screening With a Blood Test That Meets the Centers for Medicare & Medicaid Services Coverage Decision

Rosita van den Puttelaar,[1] Pedro Nascimento de Lima,[2] Amy B. Knudsen,[3] Carolyn M. Rutter,[4] Karen M. Kuntz,[5] Lucie de Jonge,[1] Fernando Alarid Escudero,[6] David Lieberman,[7] Ann G. Zauber,[8] Anne I. Hahn,[8] John M. Inadomi,[9] and Iris Lansdorp-Vogelaar[1]

What characteristics would a blood tests need to be as effective and cost-effective as FIT?

1. **Detect advanced adenomas** with sensitivity ≥ 0.40
2. **Cost less** than $125
3. **More frequent** (biennial testing)

OXFORD

JNCI: Journal of the National Cancer Institute, 2024, **00(0)**, 1–9

https://doi.org/10.1093/jnci/djae124
Advance Access Publication Date: June 6, 2024
Article

Characteristics of a cost-effective blood test for colorectal cancer screening

Pedro Nascimento de Lima, PhD,[1,*] Rosita van den Puttelaar, MS,[2] Amy B. Knudsen, PhD,[3] Anne I. Hahn, MPH,[4] Karen M. Kuntz, PhD,[5] Jonathan Ozik, PhD,[6] Nicholson Collier, PhD,[6] Fernando Alarid-Escudero, PhD,[7] Ann G. Zauber, PhD,[4] John M. Inadomi, PhD,[8] Iris Lansdorp-Vogelaar, PhD,[2] Carolyn M. Rutter, PhD[9]

Could blood tests help safety net clinics increase CRC screening rates?

- CRC screening rates are low in **F**ederally **Q**ualified **H**ealth **C**enters
  - ~ 45% adherence to screening
  - ~ 40% completion of follow-up colonoscopy
- The COVID-19 pandemic worsened already low screening rates

Could blood tests help safety net clinics increase CRC screening rates?

- CRC screening rates are low in FHQCs
  - ~ 45% adherence to screening
  - ~ **40% adherence to follow-up colonoscopy**
- The COVID-19 pandemic worsened already low screening rates

Could blood tests help safety net clinics increase CRC screening rates?

- CRC screening rates are low in FHQCs
  - ~ 45% adherence to screening
  - ~ **40% adherence to follow-up colonoscopy**
- The COVID-19 pandemic worsened already low screening rates

Annals of Internal Medicine

ORIGINAL RESEARCH

The Annual Cost of Cancer Screening in the United States

Michael T. Halpern, MD, PhD; Benmei Liu, PhD; Douglas R. Lowy, MD; Samir Gupta, MD; Jennifer M. Croswell, MD, MPH; and V. Paul Doria-Rose, DVM, PhD

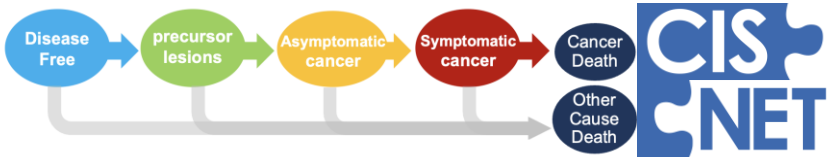
Ways to improve CRC screening adherence

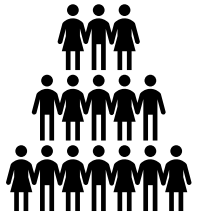
Outcomes

1. Continue to offer annual FIT (no change)
2. Offer triennial multi-target stool DNA (mt-sDNA)
3. Offer a triennial blood test
4. Continue to offer annual FIT, adding an intervention to increase completion of follow-up colonoscopy

Use modelling to project outcomes & compare approaches

1. Simulate an (unsceened) cohort

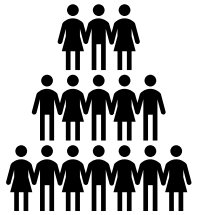




Average-risk,
50-year-old screening-eligible individuals
served by FHQCs in Southern California (**primarily Latino**)

Use modelling to project outcomes & compare approaches

1. Simulate an (unsceened) cohort



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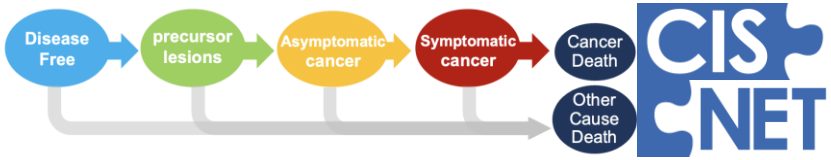


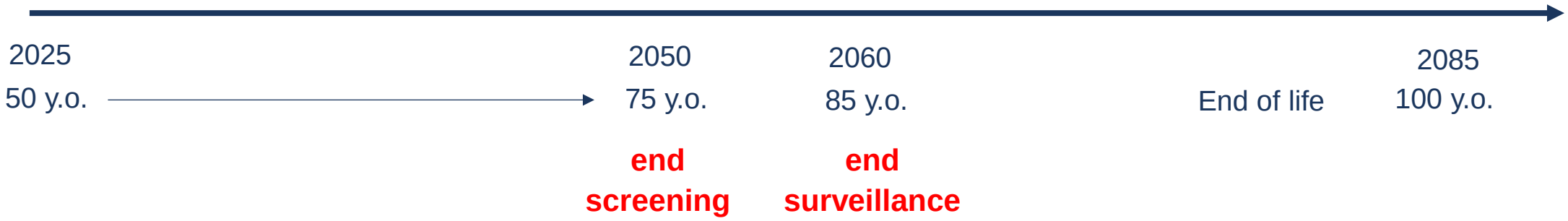
2. Simulate screening

1. Continue to offer FIT (no change)
2. Offer multi-target stool DNA (mt-sDNA)
3. Offer a blood test
4. Continue to offer FIT, adding an intervention to increase completion of follow-up colonoscopy

Simulate Screening

45%
Adherence to screening

→ 0.45 chance of completing the screening test “on schedule”



Simulate Screening

45%
Adherence to screening

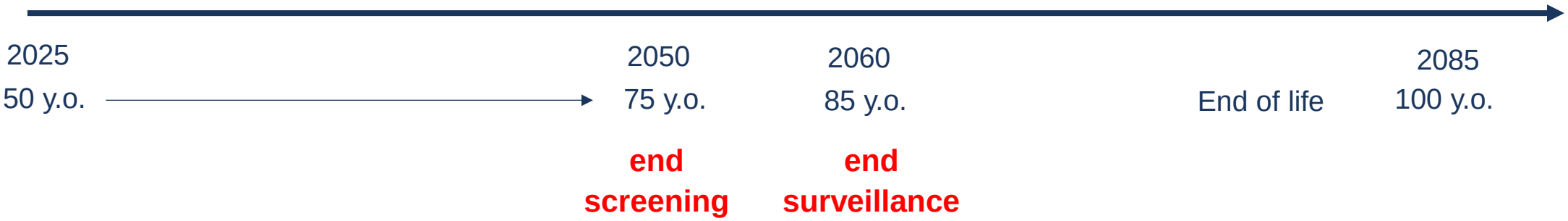
→ 0.45 chance of completing the screening test “on schedule”

Among people who never screen positive:

Annual FIT

26 screening opportunities

Expect 12 FITs completed over a lifetime



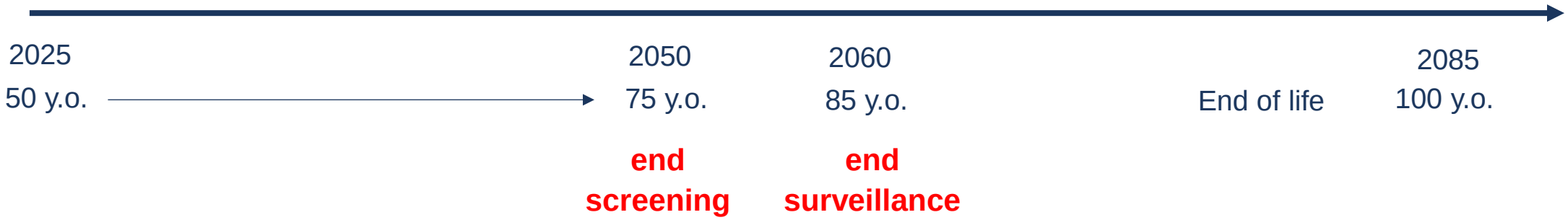
Simulate Screening

45% Adherence to screening → 0.45 chance of completing the screening test “on schedule”

Among people who never screen positive:

Annual FIT	26 screening opportunities	Expect 12 FITs completed over a lifetime
Triennial mt-sDNA	8 screening opportunities	Expect 4 mt-sDNA tests over a lifetime

Very few get all or no tests

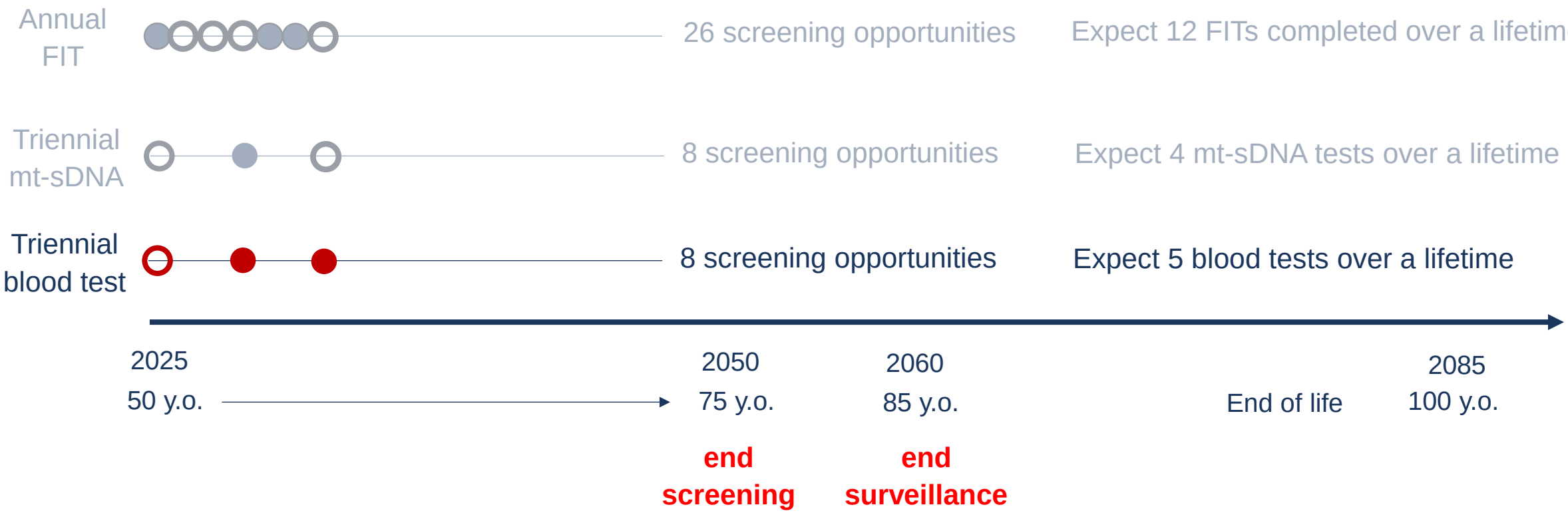


Simulate Screening

62.5%
Adherence to a blood test. screening

→ 0.625 chance of completing the screening test “on schedule”

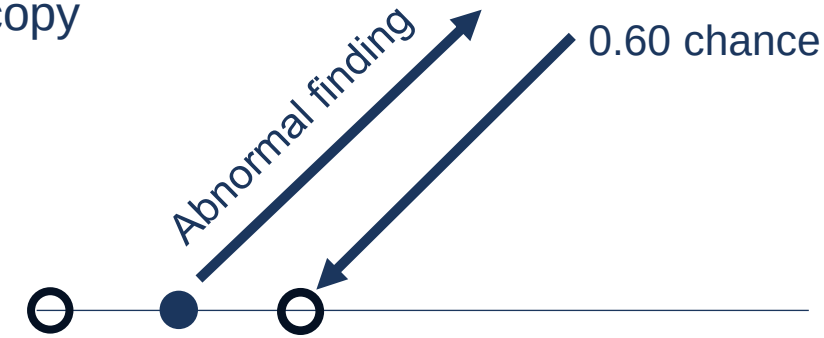
Among people who never screen positive:

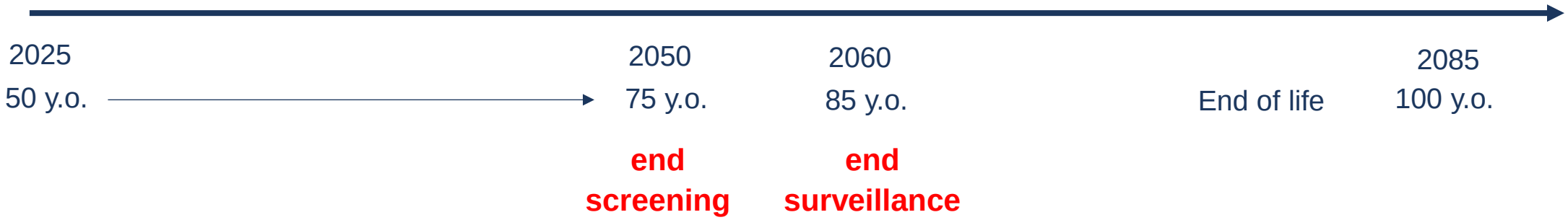


Simulate Follow-up Colonoscopy

40%
Completion of follow-up colonoscopy

0.40 chance of completing follow-up colonoscopy

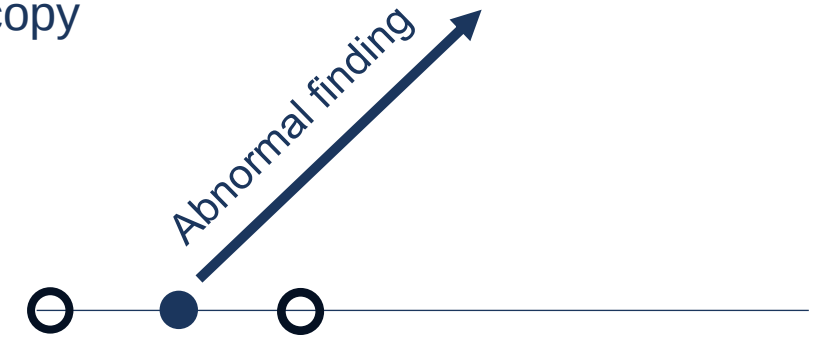




Simulate Follow-up Colonoscopy

40%
Completion of follow-up colonoscopy

0.40 chance of completing follow-up colonoscopy



Screening modality does not affect completion of follow-up colonoscopy

2025
50 y.o.

2050
75 y.o.
end screening

2060
85 y.o.
end surveillance

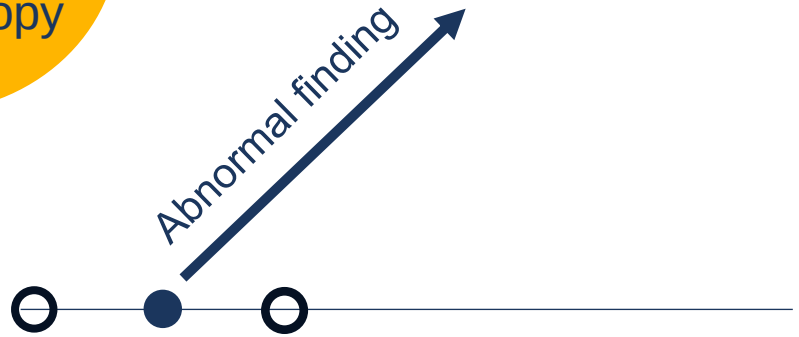
End of life

2085
100 y.o.

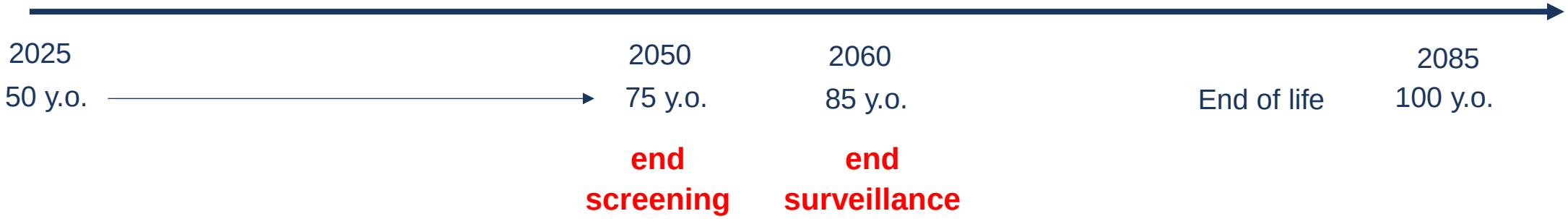
Simulate Follow-up Colonoscopy

80%
Completion of follow-up colonoscopy

0.80 chance of completing follow-up colonoscopy

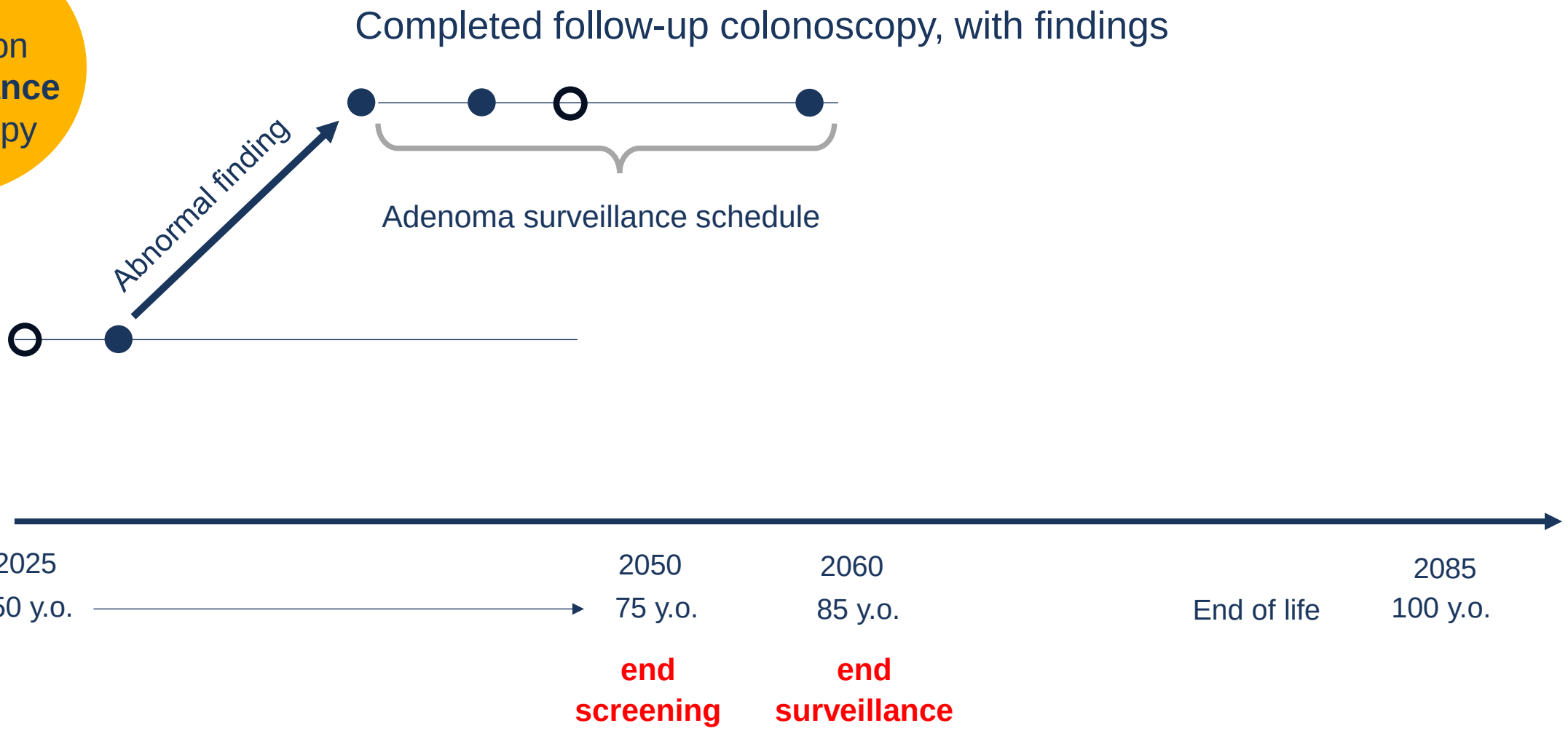


We simulated a “FIT+” scenario:
What if we used (inexpensive) FIT, but were able to bring people in for follow-up at rates seen in integrated healthcare systems?



Simulate Adenoma surveillance

80%
Completion of **surveillance** colonoscopy

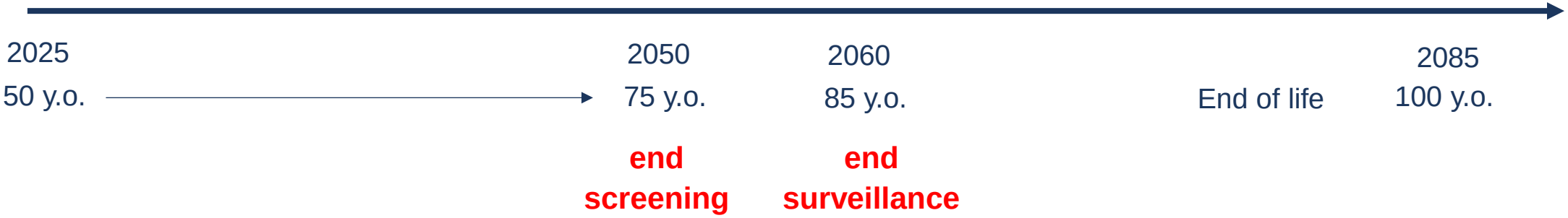


Simulate and count outcomes

- **CRC cases, time spent in each CRC stage**
- **CRC deaths**
- **Life-years**

Number of colonoscopies completed

Number of tests offered & completed



Assign costs and disutilities and cumulate outcomes

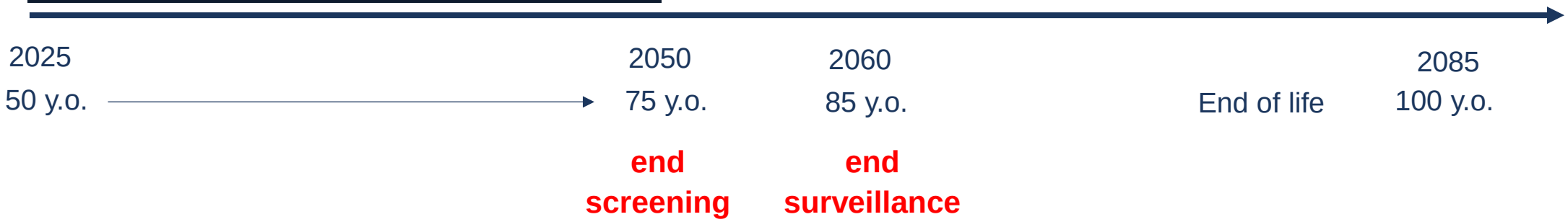
treatment $

- **CRC cases, time spent in each CRC stage**
- **CRC deaths**
- **Life-years** → **Quality Adjusted Life Years (QALY)**

Willingness
To
Pay **$100,000**

$ Number of colonoscopies completed

$ Number of tests offered & completed



Main outcomes, relative to no screening

Benefits

- Reduction in CRC cases
- Reduction in CRC deaths
- Life-years Gained (LYG)
- **Quality Adjusted LYG (QALYG)**

Net (Total) **Costs**

screening test,
follow-up & surveillance colonoscopy,
diagnosis & treatment

Net monetary benefit, NMB = WTP × QALYG – Net Costs

Willingness
To
Pay **$100,000**

Results embargoed until 1/16/2024

Why do blood tests perform poorly?

Lack of sensitivity to precursor lesions

➡ Lack of preventive effect

	Adenoma Sensitivity			Cancer Sensitivity	Specificity
	1-5mm	6-9mm	10+mm		
FIT	0.05	0.15	0.24	0.74	0.96
mt-sDNA	0.11	0.31	0.42	0.94	0.91
blood	**0.10**	**0.10**	**0.10**	0.83	**0.90**

Tests conducted less frequently

The convenience of blood tests comes at a very high cost.

Problems:

- An expensive and infrequent test that focuses on cancer detection, with little sensitivity to detect precursor lesions.
- HEDIS measures only account for the first step of screening: possible unintended consequences

Increasing completion of follow-up colonoscopy is key to reaping benefits of non-invasive screening.

Problems:

- No ‘billable’ way to pay for patient navigation & support to complete screening and follow-up
- It may be difficult to get to 80% completion of follow-up colonoscopy outside of an integrated healthcare system.

Collaborators

Fred Hutch (CRC-SPIN)

Pedro Nascimento de Lima
Laura Matrajt
Chris Maerzluft
Mohamed Albrir

“RESTORE”

Gloria Coronado
Anne Escarone

U Chicago/Argonne Labs

Nicholson Collier
Jonathan Ozik

Erasmus University (MISCAN)

Rosita van den Puttelaar
Iris Lansdorp-Vogelaar

SimCRC

Amy B. Knudsen (Mass General)
Fernando Alarid Escudero (Stanford)
Karen M. Kuntz (U Minn)

MSKCC (CISNET coordinating center)

Anne I. Hahn
Ann G. Zauber
John M. Inadomi

Fred Hutch Cancer Center

Thank you

American Cancer Society®

NATIONAL COLORECTAL CANCER ROUNDTABLE

Thank You

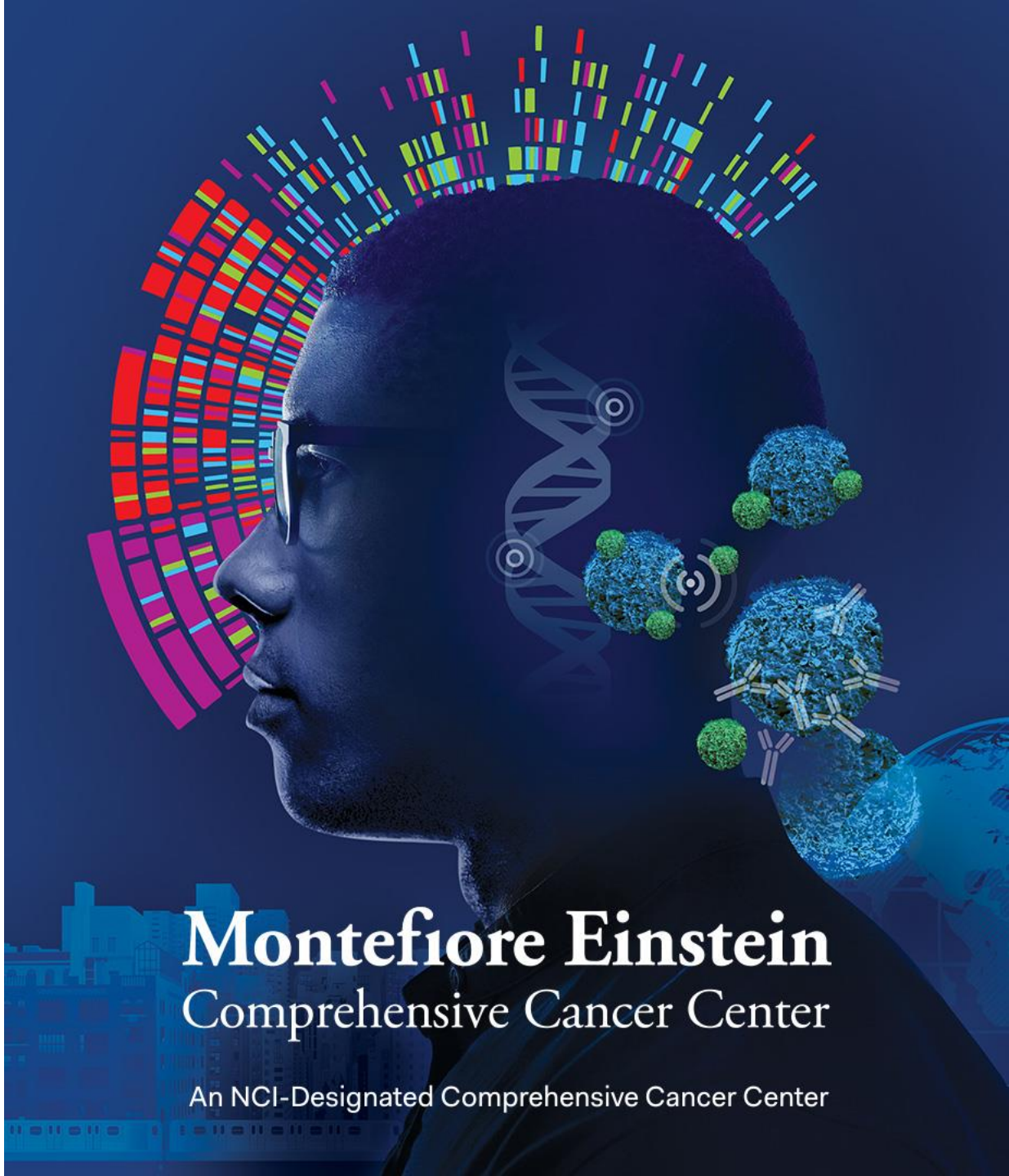
A human and AI-patient navigation partnership initiative to re-engage nonadherent patients in completing their colonoscopies

Alyson Moadel, PhD

Associate Director, Community Outreach and Engagement

Montefiore Einstein
Comprehensive Cancer Center
An NCI-Designated Comprehensive Cancer Center

NCI
Designated Comprehensive Cancer Center



Setting: Bronx, NY

Population: 1.4 million
Poverty: 31%
Race/Ethnicity:

- Hispanic 57%
- Black 44%

Foreign born: 34%
Common Ancestries:

- Dominican (22%)
- Puerto Rican (20%)
- West Indian (8%)
- Mexican (6%)
- Jamaica (5%)
- Sub-Saharan African (5%)

Non-English as primary lang: 56%
Single-person households: 32%

U.S. Census Bureau Quickfacts: Bronx County, New York, www.census.gov/quickfacts/fact/table/bronxcountynewyork/PST045223. Last updated in 2023 Accessed 23 May 2024.

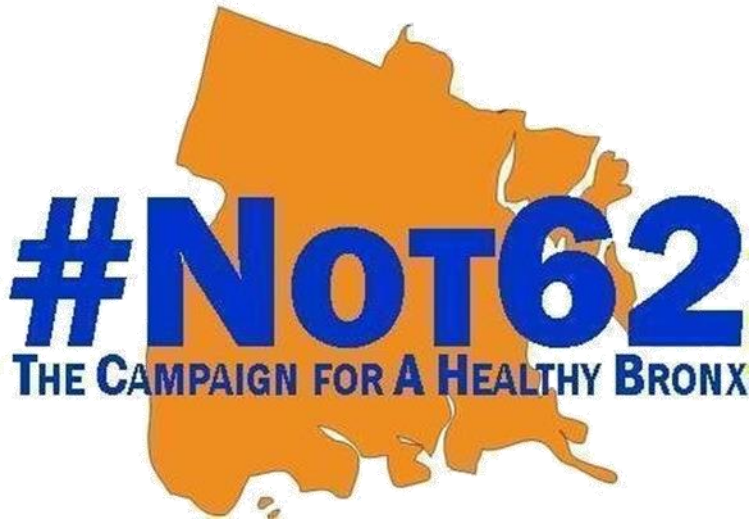
Statistical Atlas, https://statisticalatlas.com/county/New-York/Bronx-County/Ancestry, Last updated in Sep 4, 2018. Accessed 23 May 2024.

Social Determinants of Health

Bronx is the last of 62 counties in health factors

High rates of:

- Obesity
- Food insecurity
- Houselessness
- Population density
- Air pollution
- Crime
- Limited green space
- Sedentary lifestyle



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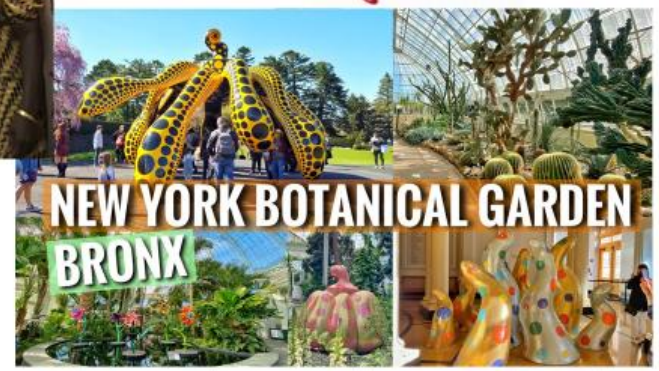
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BRONX


Uptown &
The Bronx
4
5
6


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GIVEAWAYS
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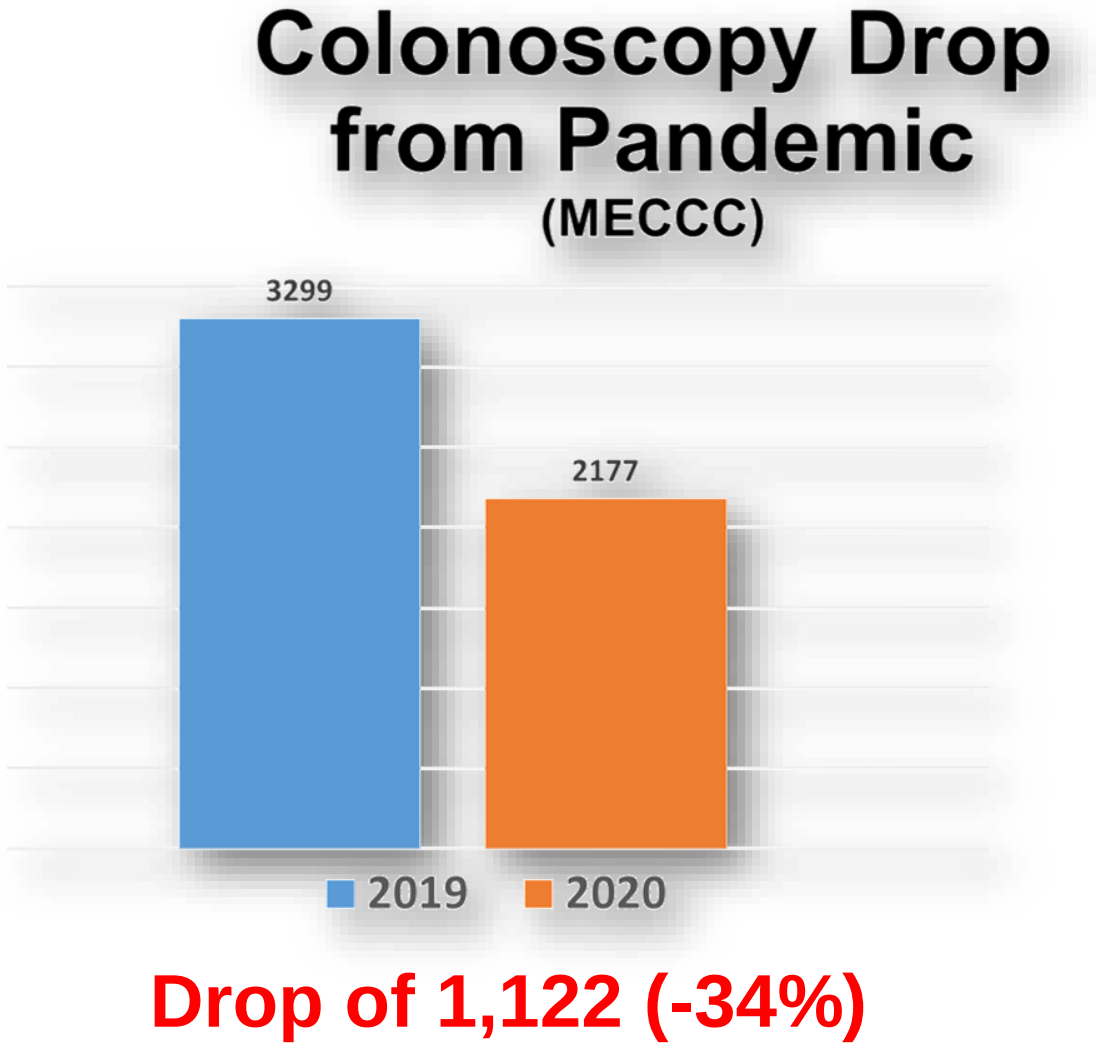
FAMILY FUN

QI Project: Community Outreach & Engagement

- **Outreach** is typically one-way communication
  - Directive, Educational
- **Engagement** is bi-directional communication
  - Facilitating, Motivating, Empowering, Addresses barriers to care
- **Opportunity:** Conversational AI Technology
  - e.g., **MyEleanor**
- **Limitations to outreach:** reduced buy-in => non-adherence
- **Limitations to Engagement:** human resources

Need: Colorectal Cancer Screening

- **Colorectal cancer disparities among people of color in the U.S. are well documented**.
  - African Americans have a 20% increased incidence of CRC >40% increased risk of dying from the disease than whites.
  - Incidence of early-onset tumors are rising more rapidly in Hispanic/Latino people than in those of any other racial and ethnic groups.



Drop of 1,122 (-34%)

Background

- Despite active outreach by professional patient navigators at a NYC cancer center serving an ethnically minoritized and disadvantaged population, **59% of 6,613 patients either cancelled or did not show for their colonoscopy in 2022**. Only 21% of this group completed it.
- With the advent of **conversational Artificial Intelligence (AI)-driven applications** within healthcare offering a potential extension to human navigators, Montefiore Einstein Comprehensive Cancer Center (MECCC) examined the use of an AI-based virtual patient navigator, **MyEleanor**, as part of a colorectal cancer screening **patient engagement quality improvement (QI) project**.

Three Campaigns:
Colorectal Cancer (CRC) Screening -- AI Navigation use cases

- **Campaign 1:** Re-engaging CRC screening non-adherent patients (Apr - Dec 2023)
  - 2,400 PTs nonadherent between late 2022 through 2023
- **Campaign 2:** Medication reminders (mid 2023)
- **Campaign 3:** Prep confirmation calls (Jan 2024)

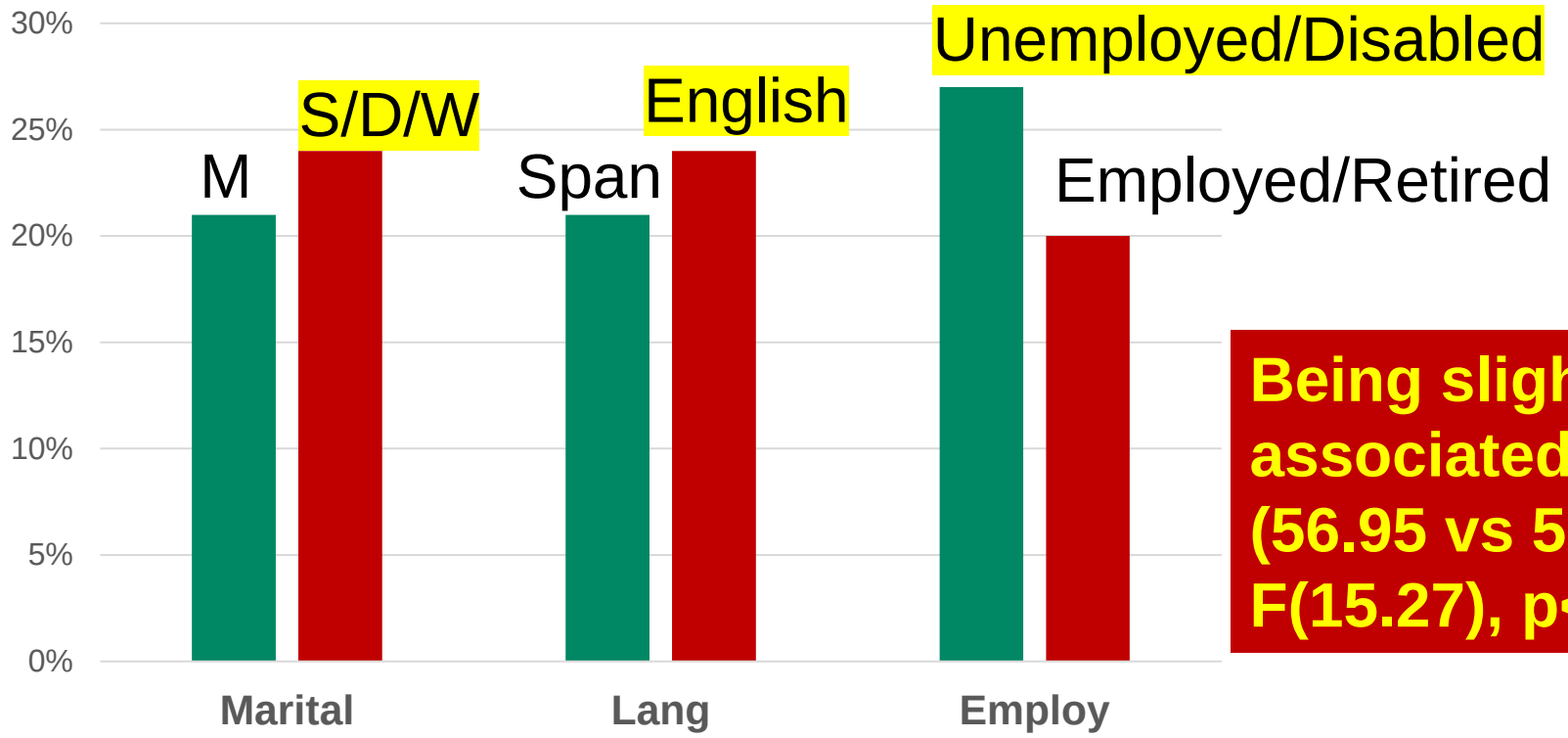
Methods

- Employed **MyEleanor between Apr-Dec 2023 to target re-engagement of 2,400 of 12,066** English- and Spanish-speaking patients nonadherent with colonoscopy appointments in 2022-2023.

- **MyEleanor, an English/Spanish speaking AI virtual navigator:**
  - (a) called patients to discuss rescheduling, (b) assessed barriers to uptake, c) offered live transfers to clinical staff to reschedule, and d) provided procedure prep reminder calls.

- **Evaluable outcomes:**
  - (a) engagement with MyEleanor, (b) live transfers accepted, (c) colonoscopy completion rate, and (d) patient volume, with (d) barriers to care, and (e) predictors of actionable engagement examined.

Who were the patients most at risk for non-adherence? (2,400 vs 8,783)



Being slightly younger was associated with lower adherence (56.95 vs 57.66 mean yrs), F(15.27), p<.001

Overall CRC Pgm Population: Hispanic (44%), Black (39%), Female (64%), English/Spanish speaking (73%/24%), Unemployed (32%), Married (43%), and mean age 57.50 (range 31-85 yrs).

About MyEleanor:

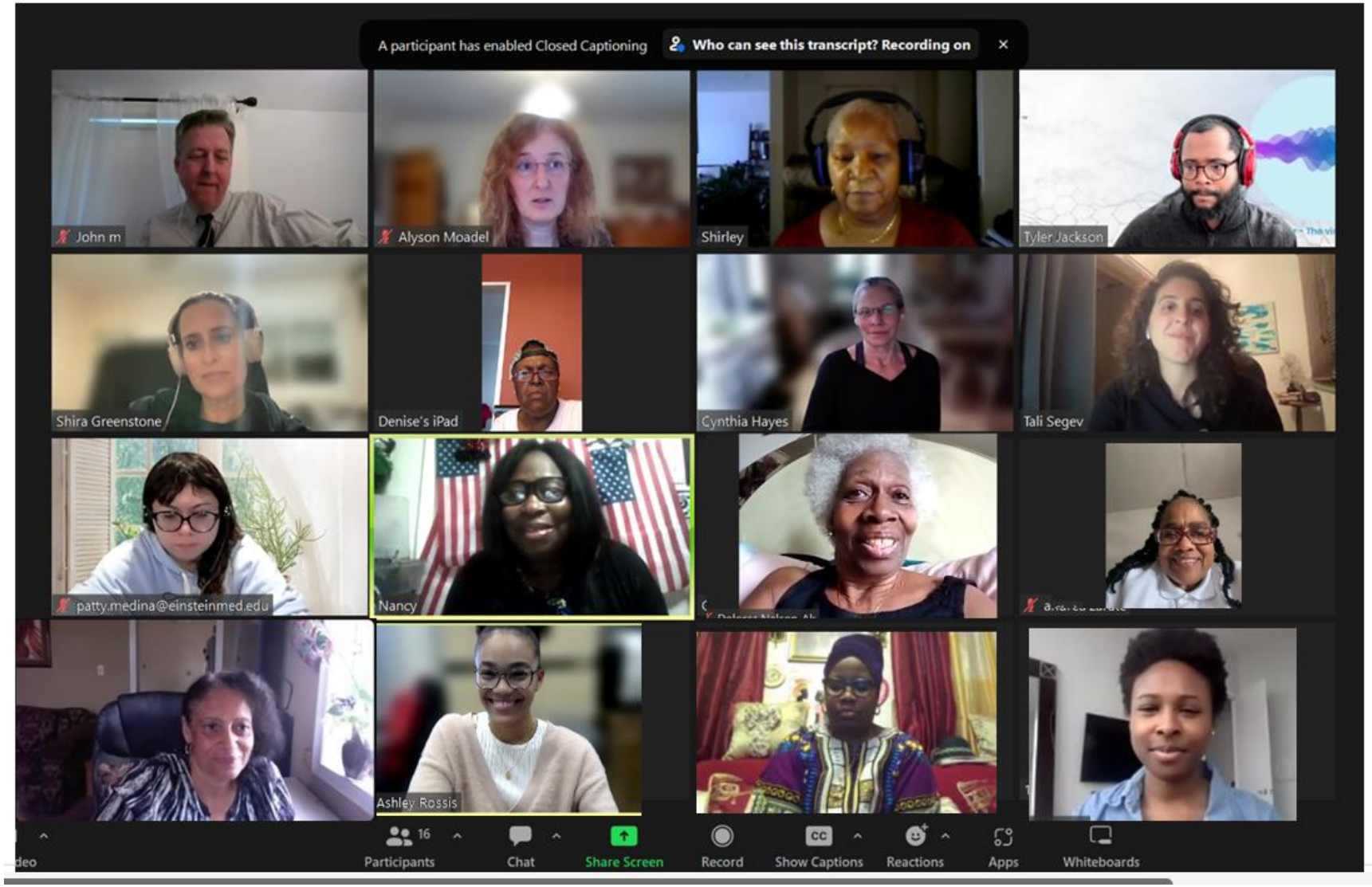
- MyndYou is a group of clinicians, technical experts, and innovators on a mission to pair simple but sophisticated technology and actionable data with a human touch to keep patients safe, engaged, and healthy in their communities.

- **MyEleanor is an AI-enabled virtual care assistant that can make thousands of highly personalized phone calls every day, complementing and offering an extension to an overstretched health care work force.**

  With the ability to detect subtle changes in a patient's voice, listening not only to what patients say, but also how they say it, MyEleanor can detect targeted needs, triage patients, and send actionable information to care team members so they can spend more time with educating, engaging, navigating and treating patients.

  MyndYou has developed sophisticated AI technology through training on thousands of clinical cases -- to create a simple, conversational approach used with patients.

Field Testing with Cancer Survivor Peer Navigators



January 2023

Curiosity
Healthy skepticism
Openness

Patient-Centered Scripting

I speak English or Spanish. Which language do you prefer? Please say English or Spanish.

I'm Eleanor, the automated care assistant for your care team at Montefiore. I am calling today because
we noticed that you missed your most recent colonoscopy appointment, and we would like to help you reschedule it at the end of this call.

First, we understand things can get in the way of getting screenings like this, and we would like to learn more so we can better assist you.

I'd like to ask you a few questions about what stopped you from coming to your appointment. This will only add an extra two minutes to the call and would help us improve our services to you and the Bronx community. Is that ok with you?

- *What were the reasons you were unable to attend your colonoscopy appointment?*
- *Thank you for sharing. Is there anything we can do to better assist you next time?*
- *Great, I will let the care team know. Just a few more steps until I can transfer you to someone who can reschedule your appointment.*

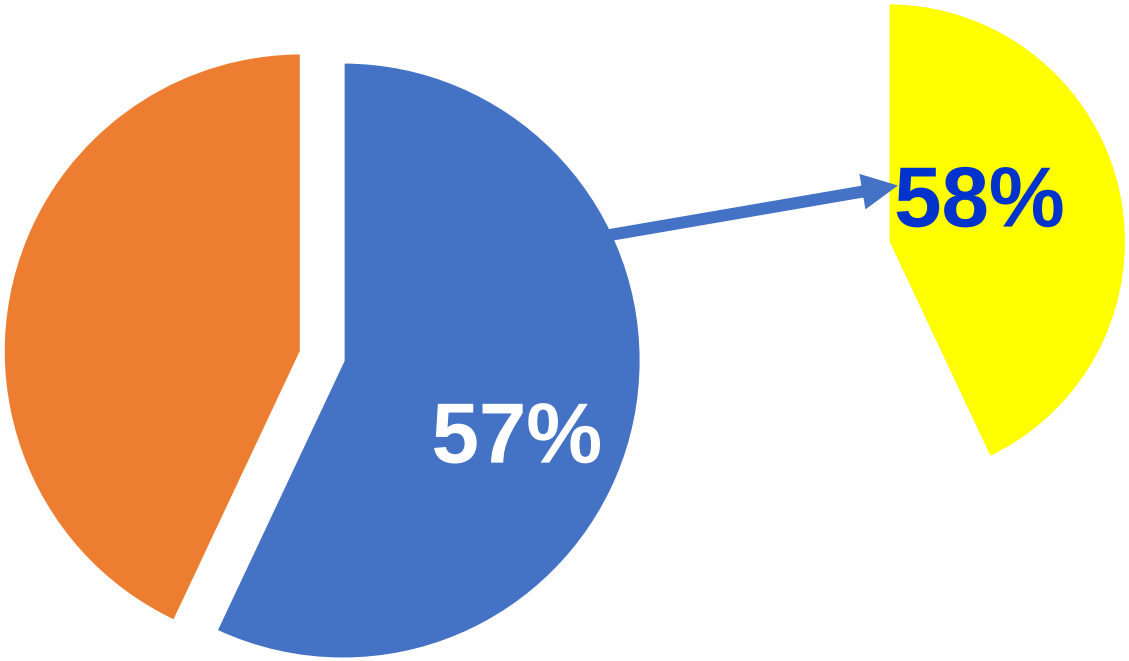
Barriers to Screening

- *I am concerned about cost or insurance. Please answer yes or no.*
- *I am afraid, embarrassed, or uncomfortable*
- *I don't think I need to be screened for cancer*
- *My doctor didn't encourage it or refer me to cancer screenings*
- *I do not have time to get tested for cancer*
- *I have concerns related to my immigration status, language abilities, or religion*
- *I do not trust doctors or the healthcare system*
- *We're halfway through the statements and you're doing great. Let's continue.*
- *I have concerns about COVID-19*
- *I worry about what they might find*
- *I fear healthcare workers will treat me differently than other patients due to my race/ethnicity*
- *I fear healthcare workers will treat me differently than other patients due to my weight*
- *I fear healthcare workers will treat me differently than other patients due to my sexual orientation*
- *I fear healthcare workers will treat me differently than other patients due to my gender identity/expression*

Results: Engagement with MyEleanor

PT Engaged with Call

1,368/2,400 (57%)



PT Accepted Live Transfer to Reschedule

789/1,368 (58%)

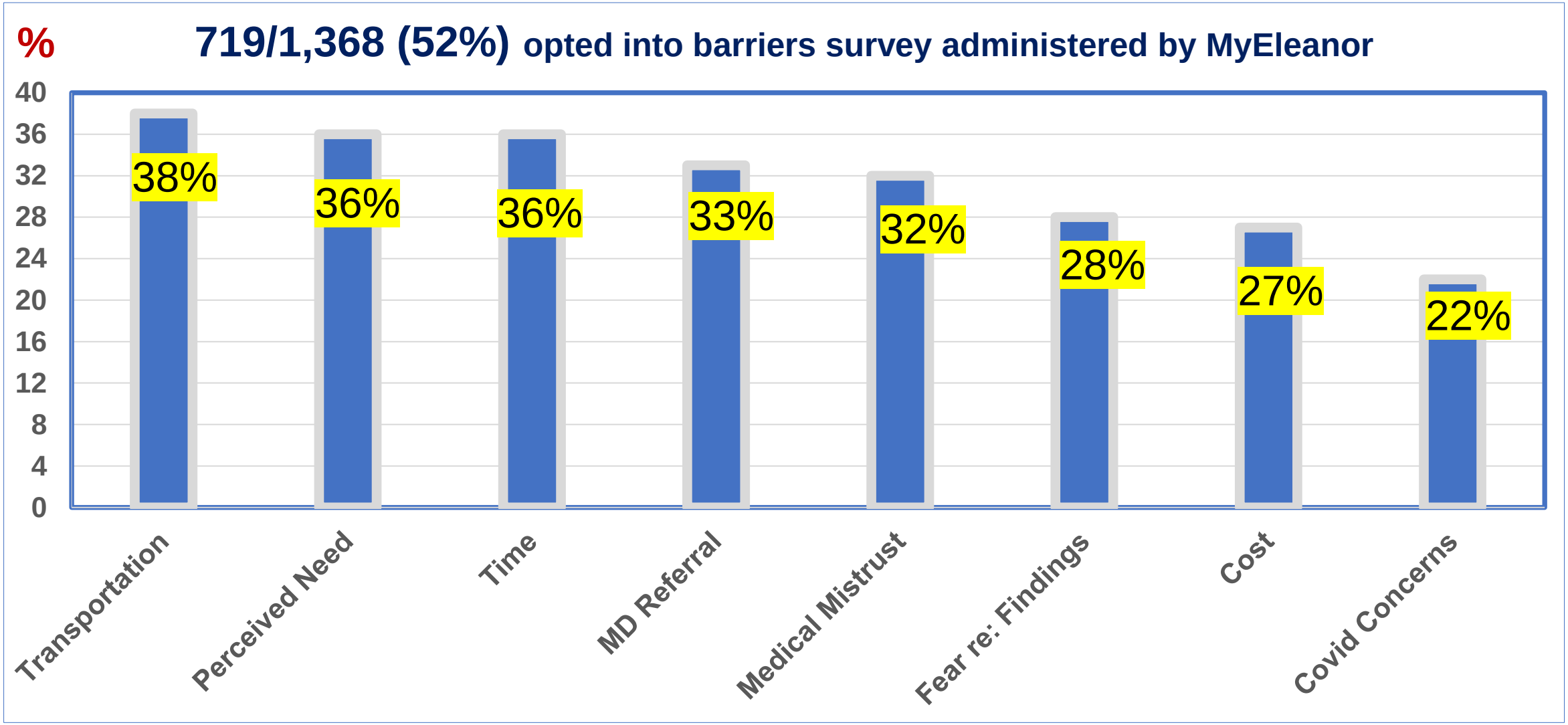
or (33% overall)

Results: Engagement with MyEleanor

- **Patients who accepted transfer were 25% more likely to complete colonoscopy**
- **No-show completion rate nearly doubled from 10% to 19%**
- **Sociodemographic predictors of engagement:**
  - Patients who engaged were a Mean age of 56.66 (41-79 yrs), female (66%), Hispanic (41%), Black (33%), English (75%) or Spanish (25%) speaking, and single/D/W (63%), and **Unemployed/Disabled (49%)**

Those unemployed/disabled accepted transfer more often (49%) than those employed/retired (41%), chisquare=6.70(4),p<0.02.

Barriers to Screening



Barriers: Predictors of Engagement/Action

<u>Accepting transfer</u>:

More likely:
- Greater # of barriers

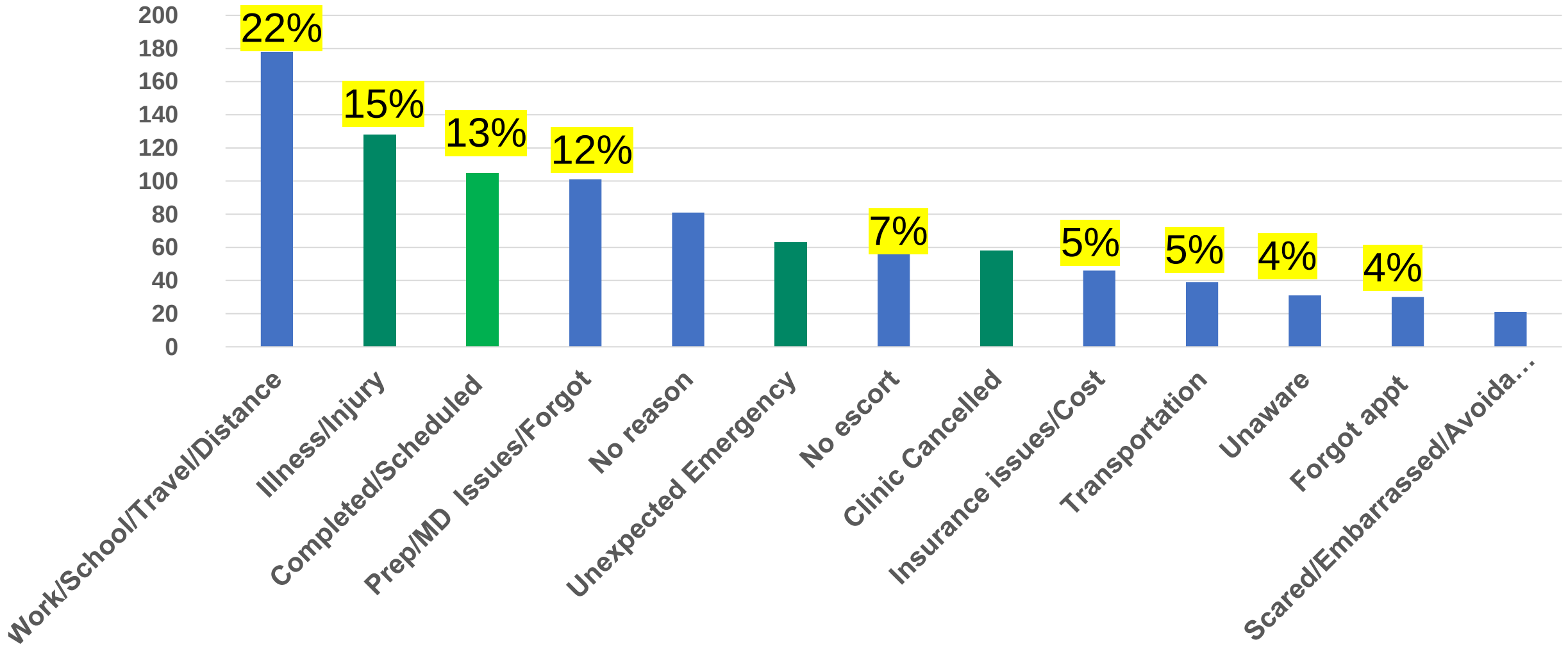
Less likely:
- Cost
- Medical Mistrust
- Cultural concerns

<u>Completing procedure</u>:

Less likely:
- Cost
- Fear (procedure/findings)

Spanish-dominant patients and those **declining to identify their race** reported nearly twice the number of barriers, $F(599)=47.48$ and $F(571)=56.66$, $p<0.001$, respectively.

What were the reasons you were unable to attend your colonoscopy appointment? n=814/2,400 (34%)

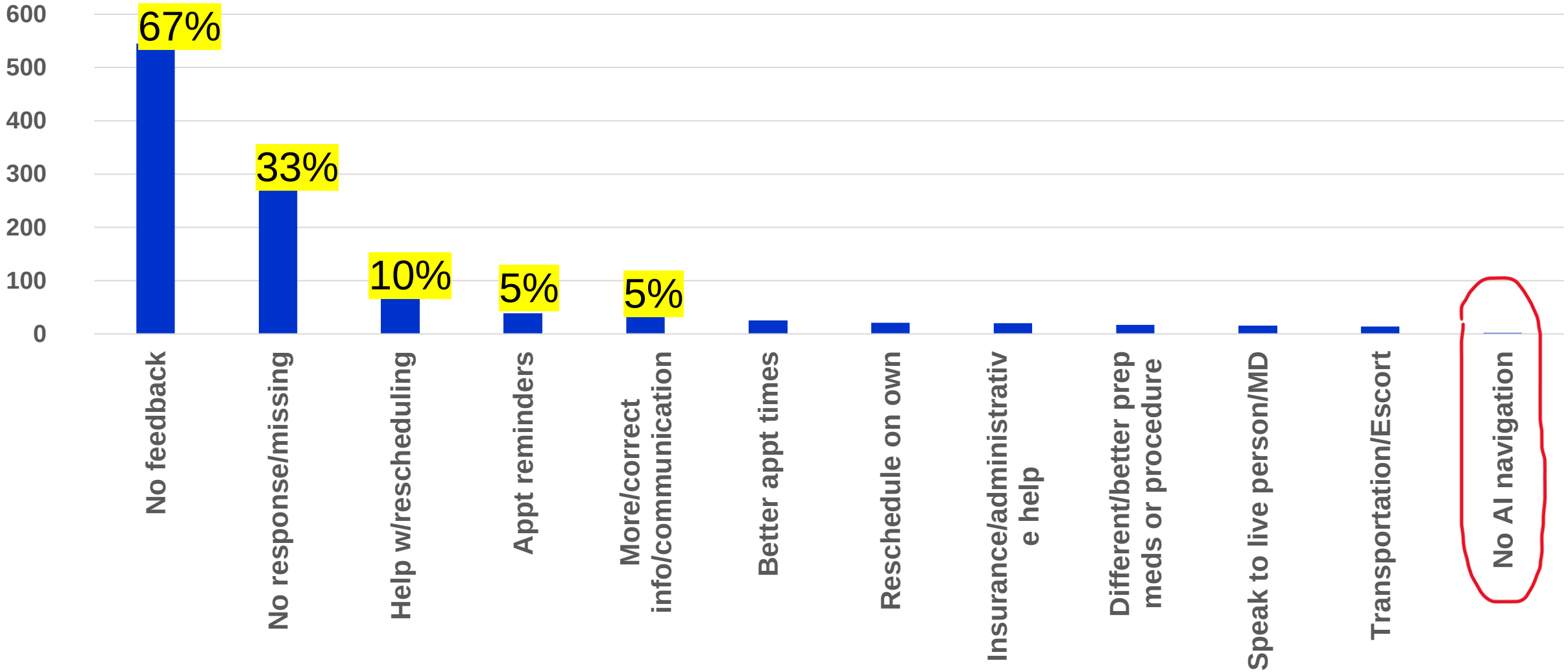


Volume Increase

- **Patient volume increased by 36% (1,363 patients)**
- **Completed colonoscopies:**
  - **2022: 3,898**
  - **2023: 5,261**
- **52 hours month freed up for 7 Patient Navigators to:**
  - **Schedule new patients**
  - **Field MyEleanor live transfer calls**

OUTREACH AND ENGAGEMENT in action

Is there anything we can do to better assist you next time? (n=814)



Conclusions

- **AI-driven virtual navigation demonstrated:**
  - feasibility through high patient acceptance and engagement
  - clinically significant impact on patient re-engagement with cancer screening
  - Increased patient volume through increasing capacity of human patient navigators
  - Ability to identify barriers to care among a substantial subgroup of patients

- **Next Steps:**
  - Measuring MyEleanor’s impact on PN burden, patient satisfaction, other screening programs (breast/lung), distress/SDOH screening, cost savings, stage shifting

- **Challenges:**
  - Integration of an outside technology application with hospital-based EMR system/tracking system – extensive data mining and synthesis efforts required!

It Takes a Village

Montefiore Einstein
Comprehensive Cancer Center

An NCI-Designated Comprehensive Cancer Center

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- **Camille Garrett, MPH,** Data Manager,
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- **Shalom Kalnicki, MD**, Director of the Cancer Service Line, Chair, Radiation Oncology

MyndYou™

- **Ruth Poliakine Baruchi, CEO**
- **Itay Baruchi, CEO**
- **Tali Segev**
- **Shira Greenstone**

It Takes a Heart

Our technology, our machines, is part of our humanity. We created them to extend ourselves, and that is what is unique about human beings.

Ray Kurzweil

Publicity photo of American entertainer, Jack Haley as Tin Man in the 1939 feature film, The Wizard of Oz.

To learn more about MyEleanor

Ruth Poliakine Baruchi
Founder, CEO

Tali & Shira

Sign up for info on upcoming Webinar!

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American Cancer Society®

NATIONAL COLORECTAL CANCER ROUNDTABLE

Thank You

Ambitious, Actionable Goals To Improve Colorectal Cancer Screening & Treatment

Anjee Davis, MPPA
Fight Colorectal Cancer

F!GHT COLORECTAL CANCER

AMBITIOUS, ACTIONABLE GOALS TO IMPROVE COLORECTAL CANCER SCREENING & TREATMENT

Read the full Colorectal Cancer Care Report (CRCCI) here:

F!GHTCRC.ORG /CRC-RESEARCH-CRCCI/

FINANCIAL DISCLAIMER:

All content in this report was developed independently and reviewed by Fight CRC staff and writing committee. While Fight CRC receives sponsorships from companies involved in CRC screening and treatment, these sponsorships did not influence the content or recommendations in this report.

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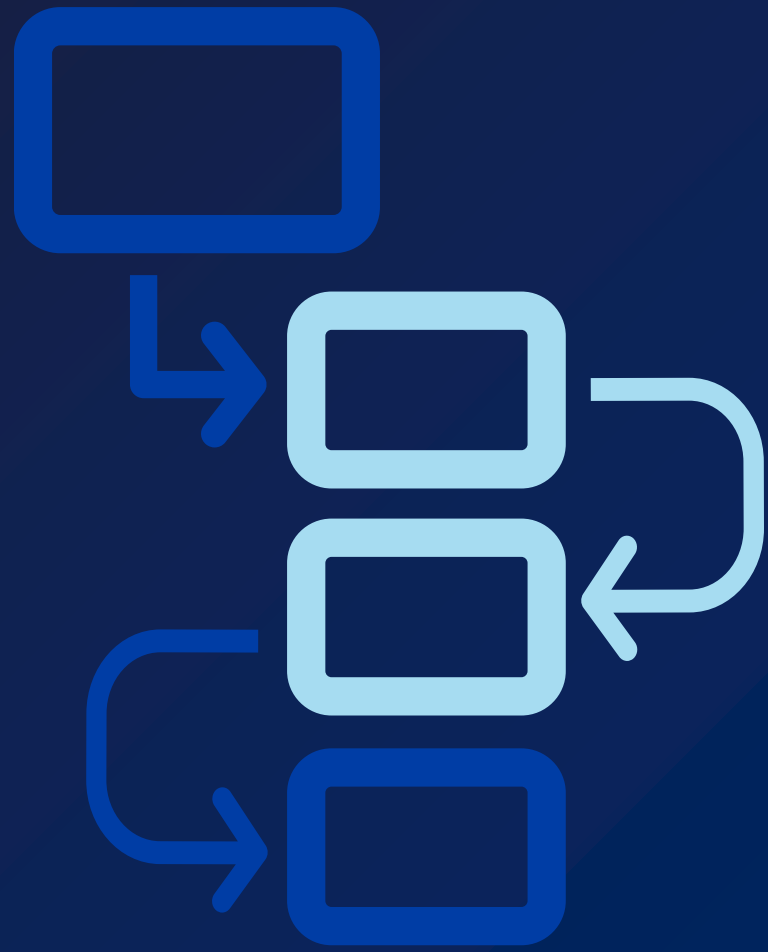
To ensure the report's recommendations are evidence-based and patient-centered, a diverse group of stakeholders reviewed all data for accuracy and impartiality.

NATIONAL COLORECTAL CANCER ROUNDTABLE

HOW DID WE GET HERE?

- ★ Moonshot Meeting in 2022
- ★ Moonshot Forum in 2023
- ★ 12 months later
- ★ Final Report 2024



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DATA AND CASE STUDIES

- Freenome
- Komodo Health
- Epic Systems
- Flatiron Health
- Exact Sciences
- Inspira Health
- American Society for Gastrointestinal Endoscopy (ASGE)
- Kaiser Permanente

THE AMOUNT OF DATA

- Epic's team analyzed their Cosmos dataset to examine the method of screening used in over 1.4 million first-time colorectal cancer screenings over a five-year period.

- Freenome performed an analysis of electronic health and claims records from 2014 to 2019 to shed light on CRC screening practices. Using a database of 8.1 billion commercial insurance, Medicare and Medicaid claims from 46 million patients, Freenome produced an analysis set of approximately 2 million screening procedures for average-risk individuals.

- Komodo Health analyzed data for 1.28 million adults diagnosed with CRC from 2016 to 2021 from a database of 330 million US patients, determining the time from an initial abnormal stool-based screening to a confirmed CRC diagnosis. The results reveal significant delays that could adversely affect patient outcomes and the effectiveness of treatment.

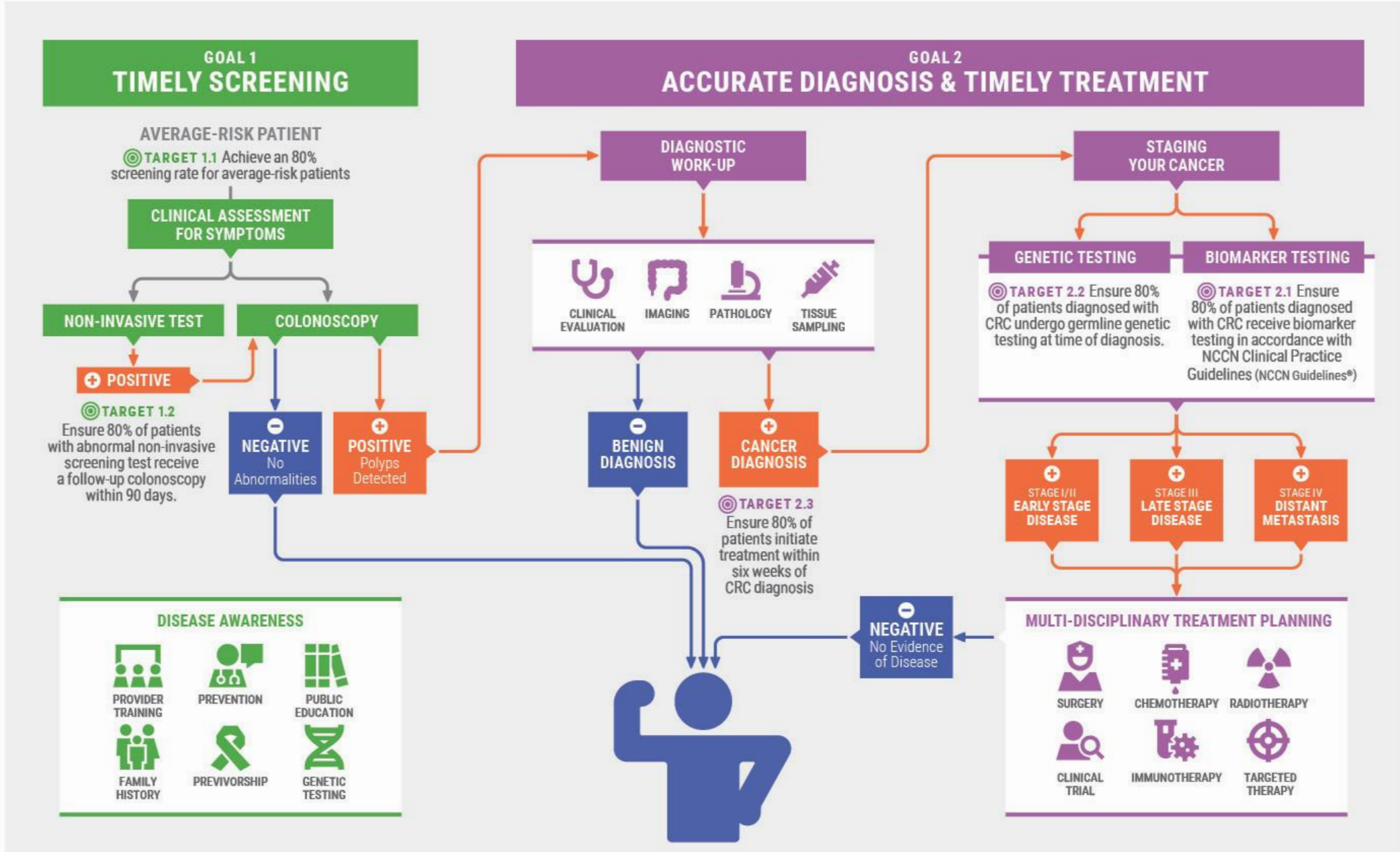
Goal 1: Timely Screening for CRC Prevention

- **Target 1.1:** Achieve an 80% screening rate for average-risk patients.
- **Target 1.2:** Ensure 80% of patients with an abnormal non-invasive screening test receive a follow-up colonoscopy within 90 days (3 months).

Goal 2: Accurate, Informative Diagnosis and Timely Treatment Initiation

- **Target 2.1:** Ensure 80% of patients diagnosed with CRC receive biomarker testing in accordance with NCCN Clinical Practice Guidelines (NCCN Guidelines®).
- **Target 2.2:** Ensure 80% of patients diagnosed with CRC undergo germline genetic testing at the time of diagnosis.
- **Target 2.3:** Ensure 80% of patients initiate treatment within six weeks of a CRC diagnosis.

Colorectal Care Pathway



NATIONAL COLORECTAL CANCER ROUNDTABLE

NEXT STEPS:

- ★ **ENDORSE THE GOALS**
- ★ **INTEGRATE THEM IN YOUR WORK**
- ★ **SHOWCASE WHAT HEALTH SYSTEMS DOING!**

CONTACT US AT: ADVOCACY@FIGHTCRC.ORG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THANKS FOR YOUR SUPPORT OF FIGHT COLORECTAL CANCER.
WE ARE STRONGER BECAUSE OF YOU.
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Thank You