



## **Colorectal Cancer Taskforce Meeting**

Date/Time:

**August 11, 2009 from 7:00 to 8:00 AM**

Location:

**American Cancer Society Office, Colorado Room  
2255 S. Oneida Street, Denver, CO 80224**

Dial-up: **1-866-910-4857**

Conference ID: **890447**

### **Meeting Notes**

#### **Attending:**

Jill Asrael – Chair

Teri Spector

Susan Rein

Holly Wolf

Andi Dwyer

Dennis Ahnen

Nikki Stob

Lynn Spencer

Pilar Chapa-Burleson

Denise Steinbach

Tracy Samora

Brian Kothe

Anne Smith

#### **Survey to CRC TF Members (Jill Asrael)**

The purpose of the survey is to collect information related to TF meeting time and to increase participation by healthcare providers and survivors. Survey results (Attachment 1) were discussed. A total of 23 CRC task force members completed the survey (CRC task force membership list from CCC website indicates 117 members). The most frequently selected reason for participation in the task force was the ability to impact cancer activities and priorities in the state. Survey respondents were generally satisfied with task force activity outcomes. Respondents indicated general satisfaction with the current meeting day and time. To increase provider participation, respondents indicated a quarterly meeting should be considered. Group discussion supported an early morning time, which for healthcare providers, is easier because it is before clinic hours begin. Meeting by conference call is okay, but phone participants indicated that it is sometimes difficult to hear speakers in the room. A work group of Susan Rein, Brian Kothe, Andi Dwyer, Dennis Ahnen, and Denise Steinbach volunteered to explore participation projects for providers. Jill and Andi volunteered to enlist Dr Told and John Sabel, respectively, to provide input. Other results discussed included having more diverse topics at the meetings where invited speakers can present/discuss relevant topics. Diversity of the TF was also discussed and

will be addressed through the possible addition of a provider subgroup and a survivor subgroup.

**Colorectal Cancer Alliance/Undy 5000, City Park, Denver** (Andrea Clay)

The national CCA has recognized the remarkable success of the inaugural Denver event. The Denver Undy was described as the “perfect storm”, where a number of factors – great partnerships, media, early financial support, volunteer efforts and great weather – coalesced and resulted in a great event. Denver’s event raised more money than any other first-time location. The CCA is looking forward to involvement in the 2010 Denver Undy. Andrea spoke of a weekend-long activity that is occurring in another State where the whole City goes “blue” for the weekend in recognition of CRC awareness and the Undy. She asked that this be considered for the 2010 event.

**National Colorectal Roundtable Toolkit** (Teri Spector)

The National Colorectal Cancer Roundtable (NCCRT), with funding from the American Cancer Society, has developed a campaign for CRC awareness. CRCTF members present were asked to view the images and complete a short survey to provide feedback about its applicability in Colorado.

**C-5 Grant** (Anne Smith, Pilar Chapa-Burleson)

July Report tabled for September meeting.

**MARCOM** (Andi Dwyer)

Andi Dwyer is stepping down as chair. New MARCOM co-chairs to be identified in September. Pilar and Anne Smith have accepted nomination of co-chairs and currently, no other nominations have been identified. The vote will occur in September at the MARCOM meeting. The Jo Jo video is currently being revised and edited-completion date set for October, 2009. Stay Tuned! MARCOM meeting will occur with Dana from ACS to learn more about the preventive services and screening legislation to build concise and clear messaging when the new legislation is to be enacted in January.

**CRC Screening Program (CCSP)** (Holly Wolf)

See Attachment II: *Evaluation Report for the Colorado Colorectal Screening Program, July 1, 2008 to June 30, 2009.*

Next Meeting: **Tuesday, September 8, 2009 from 7 to 8 AM, ACS Office, Denver**

**Attachment I**  
**Colorectal Cancer Task Force Survey**  
**August 2009**

The Colorado Colorectal Task Force is a part of the Colorado Cancer Coalition, whose mission is to bring together stakeholders to implement the colorectal cancer objectives and activities of the Colorado Cancer Plan, including strategies for the public, providers, and health care systems.

1. Professions represented: n = 29

<b>Profession</b>	<b>Number</b>	<b>Percent</b>
Physician	1	4
Health Care provider (Nurse Practitioner, Nurse, Physician Assistant)	4	17
Survivor, Advocate, Care-giver	1	4
Researcher	6	26
Health Educator	6	26
Administrator	3	13
Health Program Coordinator	2	9
Other: Quality Improvement (3); patient navigator; promontora; sales/industry	6	26

2. Primary professional setting: n = 23

<b>Professional setting:</b>	<b>Number</b>	<b>Percent</b>
Hospital	3	13
Academic	8	35
Private practice	1	4
Public health organization	1	4
Community clinic	0	0
Not for profit organization	7	30
Pharmaceutical/insurance	0	0
Other: government agency; communications firm, medical device	3	13

3. Reason for CRC task force involvement:

	<b>Most likely</b>		<b>Least likely</b>		
	<b>1</b> <b>(%)</b>	<b>2</b> <b>(%)</b>	<b>3</b> <b>(%)</b>	<b>4</b> <b>(%)</b>	<b>5</b> <b>(%)</b>
Top number represents number of respondents; lower number is the (percent) of respondents.					
Networking with others	4 (17)	8 (35)	3 (13)	4 (17)	4 (17)
Information-sharing (data, program information, events, etc.)	6 (26)	3 (13)	5 (22)	5 (22)	4 (17)
Working together to achieve the Cancer Plan strategies	6 (26)	5 (22)	5 (22)	3 (13)	4 (17)
Work to reduce duplication of services and effort	2 (9)	7 (30)	3 (13)	7 (30)	4 (17)
The ability to impact cancer activities and priorities in Colorado	9 (39)	4 (17)	2 (9)	2 (9)	6 (26)

## 4. Attend/participate in the CRC task force meetings: (n = 23)

	Number	Percent
Yes	17	74
No	6	26

## 5. In the past 12 months, the number of CRC meetings attended in-person or by telephone: (n = 23)

<b>Frequency of attendance:</b>	Number	Percent
None	4	17
Less than 3 meetings	4	17
Four to six meetings	5	22
More than 7 meetings	10	43

6. Level of satisfaction of outcomes from CRC task force activities in the past two years.  
(Respondents instructed to select “neutral/no opinion” if non-applicable or unsure about project.)

	Highly Satisfied	Satisfied	Neutral/ no opinion	Dis- satisfied	Very Dis- satisfied
Top number represents number of respondents; lower number is the (percent) of respondents.	(%)	(%)	(%)	(%)	(%)
Screen the Screener Project	4 (17)	10 (43)	9 (39)	0 (0)	0 (0)
Provide guidance to CRC Screening Program	8 (35)	9 (39)	3 (13)	1 (4)	2 (9)
9-Health Fair support	5 (22)	12 (52)	3 (13)	2 (9)	1 (4)
CRC screening guidelines	10 (43)	6 (26)	4 (17)	2 (9)	1 (4)
C-5 (Collaborating to Conquer Colorectal Cancer in Colorado) grant activities	6 (26)	7 (30)	8 (35)	1 (4)	1 (4)
Quality Forum	4 (17)	9 (39)	10 (43)	0 (0)	0 (0)
Dialog for Action	9 (39)	5 (22)	6 (26)	3 (13)	0 (0)
Advocacy training	7 (30)	5 (22)	7 (30)	3 (13)	1 (4)
CRC Cancer Plan	11 (48)	7 (30)	2 (9)	3 (13)	0 (0)
Undy 5000	11 (48)	5 (22)	4 (17)	0 (0)	3 (13)

7. Suggested projects or activities for CRC task force in next two years:
- Outreach to providers (internal medicine, ob/gyn, primary care physicians, NPs) who are the first point of entry for most people into the health care system to educate them about screening guidelines and determine if they are always directing their patients to get screened for CRC and other preventive exams and then provide 1 system, protocol for asking questions every time they have contact with a patient to ensure the patients are getting adequate preventive health education from their providers.
  - Also educating providers on prep, sedation, etc so that they can speak intelligently to their patients about the CRC exam, and also positives and negatives of all types of exams (colonoscopy v. FOBT V. flex sig, etc)
  - More web-based education
  - Working with the news channels to promote cancer screening in general and not just breast cancer
  - Working with survivors to promote screening
  - More education and educational material to primary care physicians

8. The CRC Task force has:

Top number represents number of respondents; lower number is the (percent) of respondents.	<b>Strongly agree (%)</b>	<b>Agree (%)</b>	<b>Neutral (%)</b>	<b>Disagree (%)</b>	<b>Strongly disagree (%)</b>
Recruited representatives from key sectors of the community.	3 (13)	13 (57)	3 (13)	3 (13)	1 (4)
Increased cooperation among the agencies and organizations in the community.	6 (26)	12 (52)	4 (17)	0 (0)	1 (4)
Accomplished activities or programs that otherwise would not have occurred.	13 (57)	7 (30)	1 (4)	2 (9)	0 (0)

The CRC task force meetings currently occur from 7 to 8 am on the second Tuesday of the month at the American Cancer Society office in Denver. Teleconference call-in is available.

9. Level of satisfaction with the CRC task force meetings in these areas:

Top number represents number of respondents; lower number is the (percent) of respondents.	<b>Satisfied (%)</b>	<b>Neutral (%)</b>	<b>Not satisfied (%)</b>
Project/partner updates.	16 (70)	7 (30)	0 (0)
Furthering goals of the task force and Cancer Coalition	18 (78)	5 (22)	0 (0)
Opportunity to provide input/share ideas	19 (83)	2 (9)	2 (9)
Participation by attendees both on phone and in person	14 (61)	4 (17)	5 (22)

10. Topic or presentation suggestions addressed at monthly task force meetings:

- Survivor group formation and participation
- Mid-level provider involvement
- Cross-communication with other regions/states
- Possibly more diversity topics

## 11. Day and time for monthly CRC task force meetings:

	Monday		Tuesday		Wednesday		Thursday		Friday	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
7 to 8 am	5	(28)	10	(48)	8	(40)	8	(40)	3	(21)
8 to 9 am	7	(39)	6	(29)	5	(25)	6	(30)	3	(21)
Noon Brown Bag lunch	10	(56)	7	(33)	9	(45)	11	(55)	9	(64)
1 to 2 pm	8	(44)	6	(29)	8	(40)	7	(35)	7	(50)
3 to 4 pm	11	(61)	7	(33)	9	(45)	9	(45)	6	(43)

## 12. To involve more healthcare providers in task force activities, suggested frequency for provider meetings:

Frequency of provider meetings:	Number	Percent
Monthly	1	5
Quarterly	17	81
Twice per year	2	10
Other – please specify: as needed to accomplish specific project	1	5
Total	21	100

## 13. Most likely day and time to attend provider meetings:

	Monday		Tuesday		Wednesday		Thursday		Friday	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
7 to 8 am	6	(50)	8	(62)	7	(58)	6	(50)	4	(50)
7:30 t 8:30 am	5	(42)	6	(46)	4	(33)	5	(42)	2	(25)
Noon Brown Bag lunch	7	(58)	4	(31)	6	(50)	6	(50)	5	(62)
5 to 6 pm	4	(33)	3	(23)	3	(25)	3	(25)	1	(12)
6 to 7 pm	0	(0)	1	(8)	1	(8)	1	(8)	1	(12)

## 14. Suggested projects for the CRC Provider Group and participant interest:

Provider group projects:	Number	Percent
Provider trainings/regional meetings on CRC guidelines and provider resources	12	75
Outreach to rural providers and rural health centers	10	62
Outreach to urban providers	9	56
Increase endoscopy providers in areas of need	4	25
Development of reminder systems for medical practices	9	56
Other projects: getting celebrity/high impact individuals to assist	1	6

## 15. Participation in sub-groups of the CRC Task Force:

Sub-group Participation	Number	Percent
MARCOM	7	64
Colorado Springs Colorectal Cancer Screening Initiative	4	36
Pueblo Community Mobilization Initiative	1	9
Other-please specify: Undy 5000, Pueblo CRC-ACS Summit	2	18

16. Jill Asrael is the current chair of the CRC Task Force. We are looking for a co-chair with Jill. If you, or someone you know, may be interested, please provide name, daytime phone number and email address below:  
*Andrea Dwyer indicated a possible interest.*

Other comments:

*- There was really no place for general comment so am adding this comment: it feels like the same people dominate and talk all the time...*

**Attachment II**  
**Evaluation Report for the Colorado Colorectal Screening Program**  
**July 1, 2008- June 30, 2009**

**Summary:**

A total of 3005 screens were performed on behalf of the Program in the past fiscal year. This represents 99% of our screening goal. Based on the evaluation data collection, 2743 Coloradans were successfully screened. A small portion of patients (6%) received their second screening exam (surveillance screen) this year. About 1% of those screened were reported as colorectal cancer cases diagnosed through the program. Adenomatous polyps were found in 27% of reported screens, suggesting the Program may have prevented at least 75 cancer cases this year.

**Detailed Evaluation:**

In the past 12 months (July 1, 2008 - June 30, 2009), data were compiled from 29 clinic systems that reported 2899 screens in 2743 patients.

*Demographics.* Characteristics of the individuals screened are shown in Table 1. Approximately two-thirds of those screened were women; slightly more than two-thirds were non-Hispanic White. The majority of individuals were between the target age range of 50-64, with 10 percent under the age the 50. Fourteen percent of the population screened reported having at least one first-degree relative with colon cancer. One quarter of individuals presented with symptoms. .

**Table 1: Demographics Table of patients screened between July 1, 2008 and June 30, 2009**

<b>Total completed screens</b>		<b>2899</b>	
<b>Total individuals screened</b>		<b>2743</b>	
		<b>n</b>	<b>%</b>
<b>Gender</b>	Female	1675	61%
	Male	1068	39%
	Unknown/Not Reported	0	0%
<b>Race</b>	NHW	1843	67%
	Hispanic	818	30%
	Black	11	0%
	Other	12	0%
	Unknown/Not Reported	59	2%
<b>Age Group</b>	<50	263	10%
	50-64	2428	89%
	>64	52	2%
	Unknown/Not Reported	0	0%
<b>Family History</b>	Yes	385	14%
	No	2178	79%
	Unknown/Not Reported	180	7%
<b>Symptomatic</b>	Yes	692	25%
	No	2042	74%
	Unknown/Not Reported	9	0%

*Outcomes.* Table 2 summarizes the results for screening procedures and pathology outcomes. Slightly more than half of all screens were positive (tissue was removed and sent to pathology). In cases where more than one biopsy specimen was taken, pathology results reflect the most severe histology. Pathology reports indicated that about half of tissue/polyps removed were adenomas, precancerous lesions of the colon.

**Table 2: Screen and pathology results for patients screened from July 2008 to June 2009**

		n	%
<b>Screen Results</b>	Normal	1293	47%
	Positive/Biopsied	1446	53%
	Pending/Not Reported	4	0%
<b>Pathology Results</b>	Adenoma	752	27%
	Benign/Hyperplastic	436	16%
	Other/Unknown	134	5%
	No Diagnostic Abnormality	75	3%
	Pending/Not Reported	22	1%
	Cancer	27	1%

*Process Outcomes.* The Program collects several process-related outcomes in order to monitor effectiveness of outreach efforts and navigation activities (see Table 3 below) and quality of the exams (Table 1). With respect to outreach, clinics are asked to collect information on how the patient heard about the Program. Almost all patients reported being referred to the Program by their clinic. Very few patients, 3%, required transportation assistance for their exam and 4% required translation services. Most exams (96%) were reported as adequate meaning that the cecum was reached and the quality of the preparation was adequate or better.

**Table 3: Process related outcomes (N =2743)**

		n	%
<b>Referral Source</b>	Clinic In-reach	2721	99%
	Brochure	5	0%
	Media	1	0%
	Unknown/Not reported	16	1%
<b>Transportation Assistance Provided</b>	Yes	79	3%
	No	2664	97%
	Unknown/Not reported	0	0%
<b>Translation Assistance Provided</b>	Yes	98	4%
	No	2645	96%
	Unknown/Not reported	0	0%

*Data Collection.* In September of 2008, the Program successfully migrated from individual ACCESS databases housed at each clinic to the eCRC system. ECRC is a web-based data collection system that is maintained at CDPHE, and was modeled after the current eCast database that is used for the breast and cervical screening program. The new eCRC system simplifies data collection and allows for real-time monitoring of clinical and process outcomes. CDPHE provides weekly data transfers containing de-identified data to the Evaluation team at the coordinating center for the management of the data. On-going clinic support is provided through patient navigation conference calls and by quality assurance clinic audits to assure good data reporting accuracy.

*Quality Assurance Measures.* Based on recommendations from the Medical Quality Advisory Committee (MQAC), three additional clinical data elements have been added to the collection of data in eCRC.

These measures are the cecum intubation rate (whether or not the exam successfully reached the cecum) and the quality of the bowel preparation and whether or not the patient was given their exam results and told when to return for their next exam. The cecum intubation rate and the preparation quality measures, along with the proportion of positive screening exams, will be shared with providers for their review and internal monitoring.

*Surveillance Monitoring and other data enhancements.* Based on the recommendation of the MQAC two questions to monitor surveillance were added to eCRC : the age of diagnosis for a first degree relative with colon cancer or adenomatous polyps and the number of adenomas removed during the exam. Lastly, eCRC was modified in order to include the additional screening option of CT colonography in those people where colonoscopy is contraindicated.

*Data Quality Audits.* A random sample of 20% of patients screened at each clinic this fiscal year or 10 patients, whichever was greater, was selected for review. A combination of on-site clinic audits and virtual audits were conducted. Virtual audits were comprised of de-identified medical records (patient intake forms, endoscopy and pathology reports) for selected patients sent to the Program's Evaluation team by the community clinics. Based from the five on-site audits, the quality of the data being reported to CCSP was very high. Very few recommendations were made to clinics to improve the data collection process across clinics and to improve upon the already high accuracy rate. Data entry accuracy results from the five clinics range from 88 – 99% accurate.

*Patient Satisfaction Survey.* Two hundred patient satisfaction surveys were mailed in June 2009 to patients who were screened between December of 2007 and December of 2008. To date, 84 surveys, 42%, have been returned to CCSP. Already, this is a higher return rate than was seen last year. This is perhaps due to the \$10 gift card that was included with the surveys this year. Data analysis is planned in first quarter of the next fiscal year after more surveys are received.

*Program Screening Reach:* The Colorado Colorectal Screening Program reaches throughout the state, with the exception of the San Luis Valley supported by the Care Free Colon Project. The Care Free Colon Project will merge into the Program in the first quarter of the next fiscal year. Statewide, thirty one clinic systems participated in the Program this year. Ninety four percent of the clinics provided data for this report. Figure 3 shows the percentage of annual screens performed this year in the following regions: Denver Metro, Northeast, Northwest (including North Central), Southeast and Southwest. The distribution of screens carried out in each area is roughly proportionate to the distribution of the patient population eligible for the Program. Similar analyses by urban/rural area and community clinic affiliation are underway.

**Figure 3: Percentage of patients screened by region**