# Roundtables: How and Why They Work

## National Lung Cancer Round Table
## Inaugural Meeting, December 11-12, 2017

**Robert A. Smith, PhD**
**Vice President, Cancer Screening**
**American Cancer Society**
**Atlanta, GA**

# 21 YEARS AGO, THE ACS AND CDC ESTABLISHED THE NATIONAL COLORECTAL CANCER ROUNDTABLE (NCCRT)

The NCCRT is a national coalition of public, private, and voluntary organizations whose mission is to advance colorectal cancer control efforts by improving communication, coordination, and collaboration among health agencies, medical-professional organizations, and the public.

# NATIONAL COLORECTAL CANCER ROUNDTABLE (NCCRT)

- TODAY—It is a collaborative partnership of over 100 member organizations
- Includes many nationally known experts, thought leaders, and decision makers on colorectal cancer
- Work is conducted throughout the year through various Task Groups and Special Topic Meetings
- Annual meeting addresses important topics and sets the following year's agenda

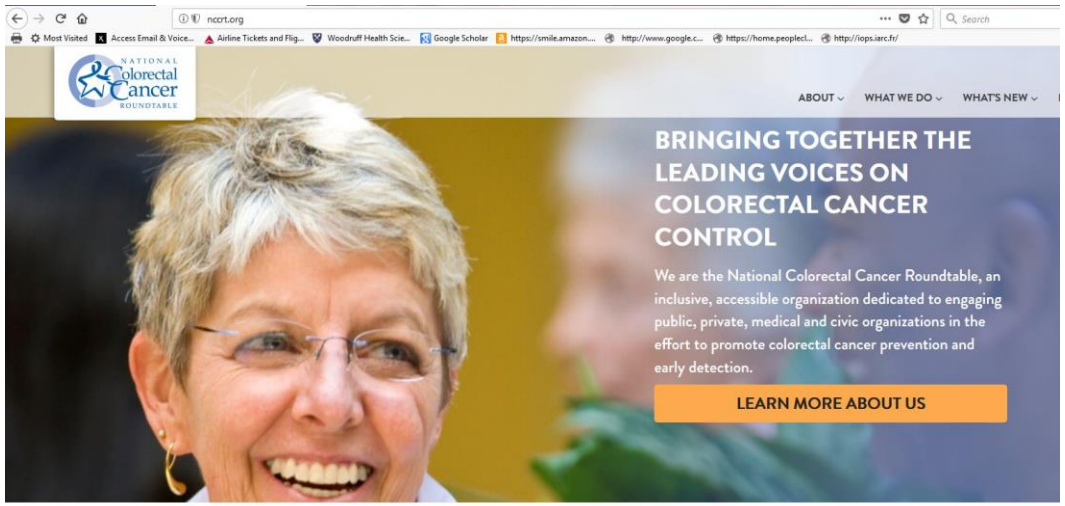
American Cancer Society®

NATIONAL Colorectal Cancer ROUNDTABLE

# Roundtables Have Become an ACS Cancer Control Strategy

- National Colorectal Cancer Roundtable
- National HPV Vaccination Roundtable
- National Lung Cancer Roundtable
- National Smoking and Behavioral Health Initiative
- National Navigation Roundtable
- National Survivorship, Patient and Caregiver Support Roundtable

# NCCRT & NHPVRT Have Web Pages to House Important Information & Resources

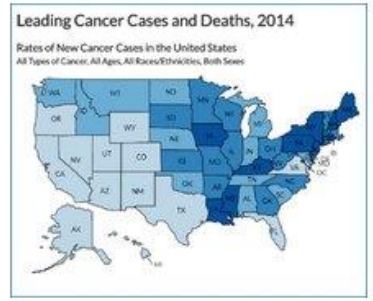



Colorectal Cancer Screening Best Practices Handbook For Health Plans – March 28, 2017


This webinar introduced the new NCCRT Colorectal Cancer Screening Best Practices Handbook for Health Plans.

2017 80% By 2018 Communications Guidebook: Recommended Messaging To Reach The Unscreened


United States Cancer Statistics: Data Visualizations




This resource provides interactive data visualizations of official federal statistics on cancer incidence and deaths.

EXTERNAL PARTNER

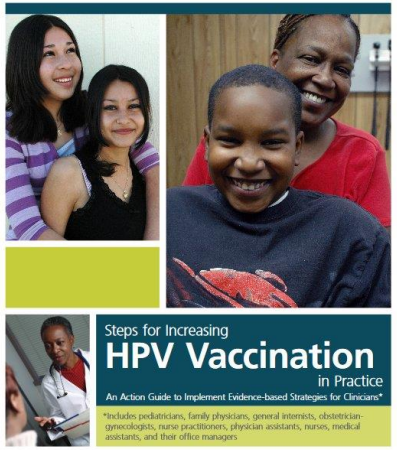
## The National HPV Vaccination Roundtable

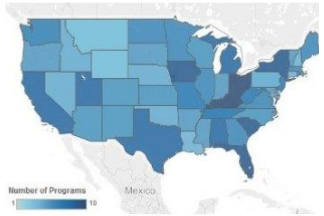
The National HPV Vaccination Roundtable, established by the American Cancer Society (ACS) and the Centers for Disease Control and Prevention (CDC) in 2014, is a national coalition of public organizations, private organizations, voluntary organizations, and invited individuals dedicated to reducing the incidence of and mortality from HPV-associated cancer in the U.S., through coordinated leadership and strategic planning.

National HPV Vaccination Roundtable

**Our Goals**

**The Need**




## HPV Vaccination Initiative Contact Map

The HPV Vaccination Initiative Contact Map provides contact information for various HPV vaccination initiatives. This map provides a visual display of U.S. HPV vaccination uptake initiatives/interventions that is public and searchable by state and organization and project type.

For more information on this tool, please contact acs.hpvvacs@cancer.org

# National Lung Cancer Roundtable (NLCRT)

- Established in late 2016, with a 3 year $1.5 million grant from AstraZeneca, and in-kind ACS support

- In a multi-organization advocacy effort to influence CMS to cover lung cancer screening for Medicare beneficiaries, ACS committed to establishing the NLCRT to unite key organizations to work together to insure high quality at every step of the lung cancer screening process

# FROM THE CMS COVERAGE DECISION …

CMS strongly encourages eligible facilities to implement the necessary components of a high quality LDCT lung cancer screening program as recommended by multi-society stakeholders. ***In addition, we support the development of a multi-society, multi-disciplinary governance body to continue to refine and optimize screening practices over time.*** CMS would gladly participate.”

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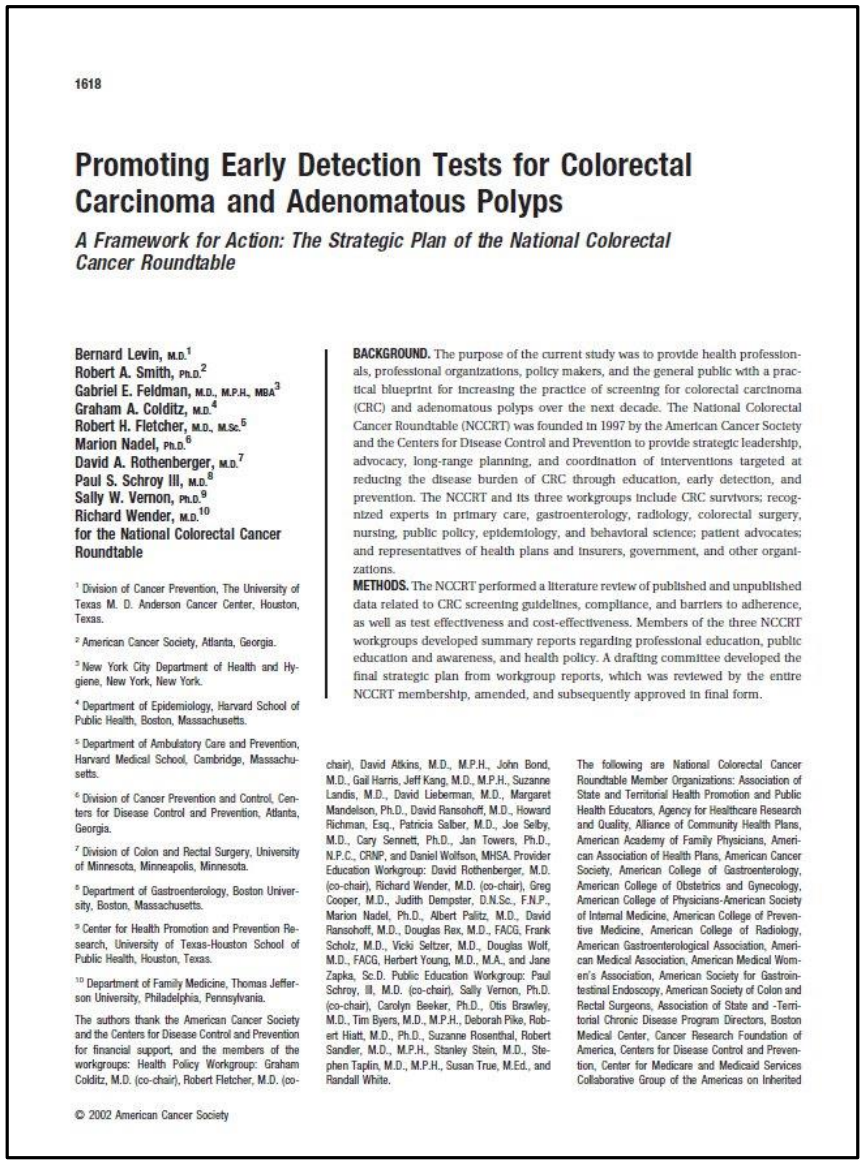
# A Few Words About Roundtables

# Roundtable Principles

- A Roundtable acts as a catalyst to stimulate work on key issues.
- The work of a Roundtable is guided by its **strategic plan,** with direction and input from an active **Steering Committee,** and conducted by area-specific **Task Groups**.
- A fundamental premise of a Roundtable is that collective action among the member organizations will be more successful in reducing the burden of disease, and reducing that burden faster, than if we worked alone.

# NCCRT Strategic Plan (2002)



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## Promoting Early Detection Tests for Colorectal Carcinoma and Adenomatous Polyps

*A Framework for Action: The Strategic Plan of the National Colorectal Cancer Roundtable*


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Robert A. Smith, Ph.D.[2]
Gabriel E. Feldman, M.D., M.P.H., MBA[3]
Graham A. Colditz, M.D.[4]
Robert H. Fletcher, M.D., M.Sc.[5]
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**BACKGROUND.** The purpose of the current study was to provide health professionals, professional organizations, policy makers, and the general public with a practical blueprint for increasing the practice of screening for colorectal carcinoma (CRC) and adenomatous polyps over the next decade. The National Colorectal Cancer Roundtable (NCCRT) was founded in 1997 by the American Cancer Society and the Centers for Disease Control and Prevention to provide strategic leadership, advocacy, long-range planning, and coordination of interventions targeted at reducing the disease burden of CRC through education, early detection, and prevention. The NCCRT and its three workgroups include CRC survivors; recognized experts in primary care, gastroenterology, radiology, colorectal surgery, nursing, public policy, epidemiology, and behavioral science; patient advocates; and representatives of health plans and insurers, government, and other organizations.

**METHODS.** The NCCRT performed a literature review of published and unpublished data related to CRC screening guidelines, compliance, and barriers to adherence, as well as test effectiveness and cost-effectiveness. Members of the three NCCRT workgroups developed summary reports regarding professional education, public education and awareness, and health policy. A drafting committee developed the final strategic plan from workgroup reports, which was reviewed by the entire NCCRT membership, amended, and subsequently approved in final form.


The following are National Colorectal Cancer Roundtable Member Organizations: Association of State and Territorial Health Promotion and Public Health Educators, Agency for Healthcare Research and Quality, Alliance of Community Health Plans, American Academy of Family Physicians, American Association of Health Plans, American Cancer Society, American College of Gastroenterology, American College of Obstetrics and Gynecology, American College of Physicians-American Society of Internal Medicine, American College of Preventive Medicine, American College of Radiology, American Gastroenterological Association, American Medical Association, American Medical Women's Association, American Society for Gastrointestinal Endoscopy, American Society of Colon and Rectal Surgeons, Association of State and -Territorial Chronic Disease Program Directors, Boston Medical Center, Cancer Research Foundation of America, Centers for Disease Control and Prevention, Center for Medicare and Medicaid Services Collaborative Group of the Americas on Inherited



- "To increase CRC screening rates, the issues of patient and physician barriers to screening, lack of universal coverage, lack of incentives to motivate adherence, and expanded infrastructure must be addressed."

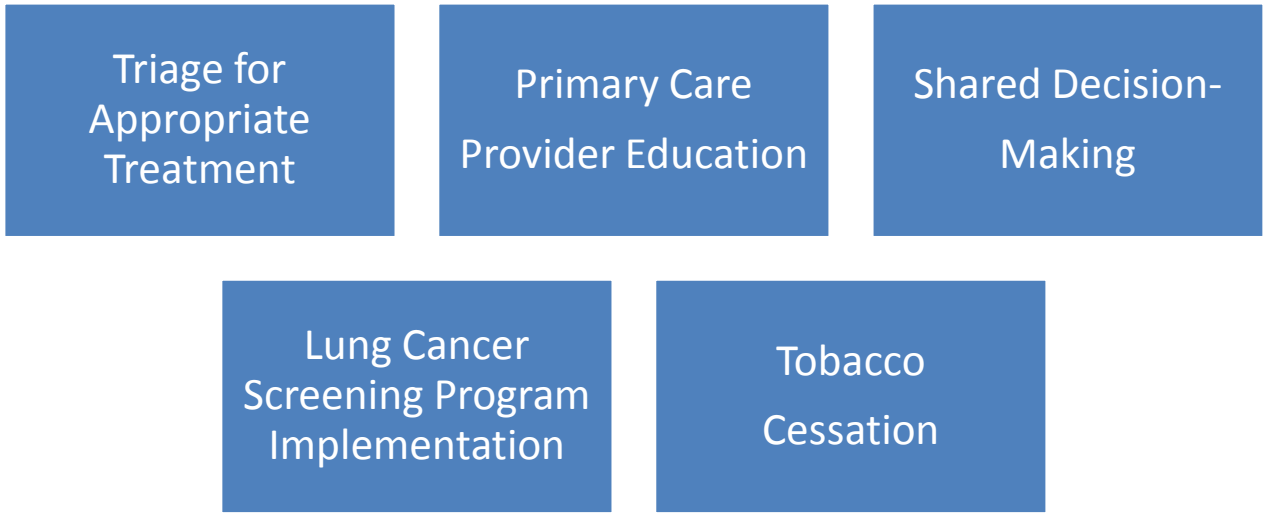
Cancer 2002;95:1618–28

# NLCRT Governance

## Steering Committee (12 members)

## Bylaws Committee and Membership Committee (in progress)

# INITIAL NLCRT Task Groups



# Roundtable Principles (2)

- A core principle of the NCCRT is that it will not duplicate or take on roles of member organizations, but rather will enhance those roles, ***and fulfill roles that would otherwise go undone.***
- Together members share information, identify needs and opportunities, and address gaps in research, programs, activities, and services.
- The strength of these partnerships, united in mission, enhances the work of each member and thus effectively furthers our collective cause.

# Core Roundtable Operating Principles

***Don'ts***

- Duplicate member organization roles
- Compete with member organizations
- Take on positions or projects that are in conflict with member organizations

***Do's***

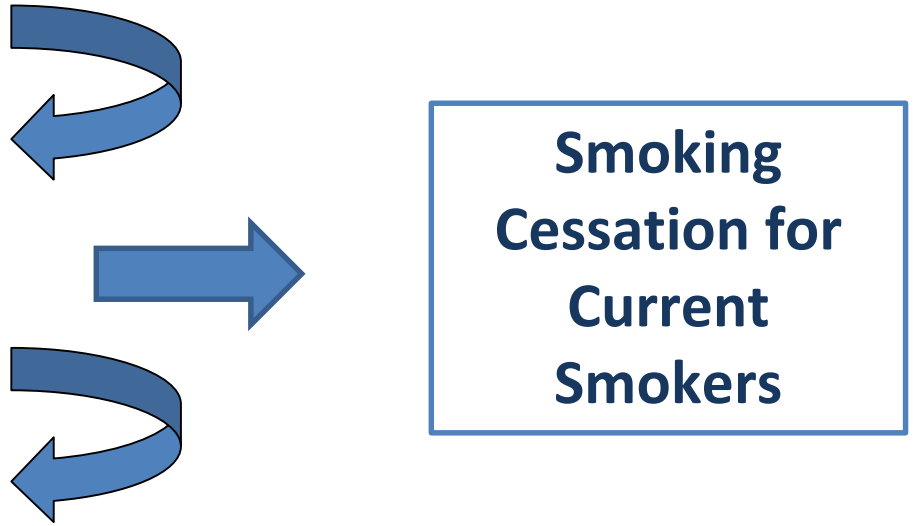
- Serve as a Forum
- Provide the "Big Tent"
- Challenge the membership to be participatory, and to regard the NLCRT as a "go to" organization
- Identify unmet needs (GAPS)
- Stimulate collaborations to address those needs
- Support projects best conducted independently

# National Lung Cancer Roundtable (NLCRT)

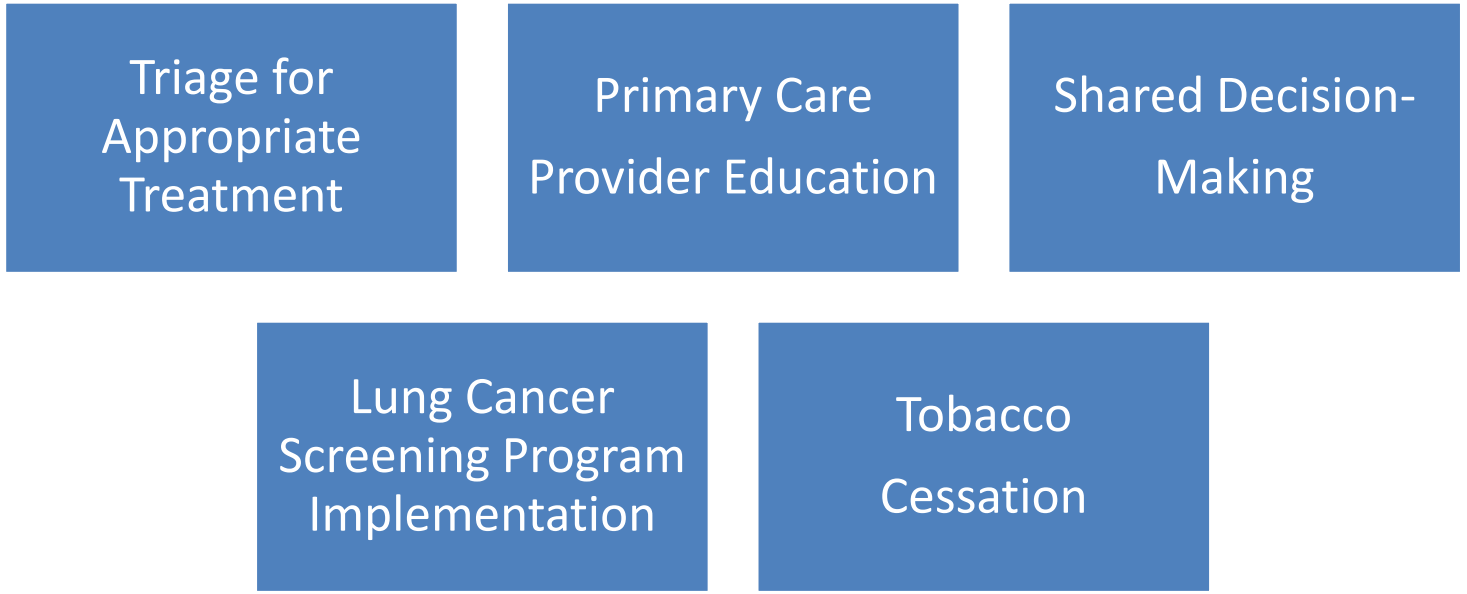
- Includes the important, national organizations and experts focused on lung cancer screening, tobacco treatment, nodule management, therapy, and survivorship…..this membership will grow over time
- Work is conducted throughout the year through various Task Groups and Special Topic Meetings
- Annual Meeting addresses important topics and sets the following year’s agenda

# Lung Cancer Screening & Follow-up is a Cascade of Events

- A target population
- Referring MD's
  - (information & referral)
- The Screening Test
  - High quality image
  - High quality interpretation
  - High quality evaluation of positive results
  - Management of patients in surveillance for small pulmonary nodules
- Triage to Appropriate Diagnosis and Therapy



# INITIAL NLCRT Task Groups




- Three new Task Groups will be added in 2018
- Task Groups can generate “subgroups”
- Task Groups can stimulate Workshops to address specific issues
- These Workshops commonly generate published manuscripts

- Existing roundtable tools can easily be adapted to lung cancer
- New tools will be developed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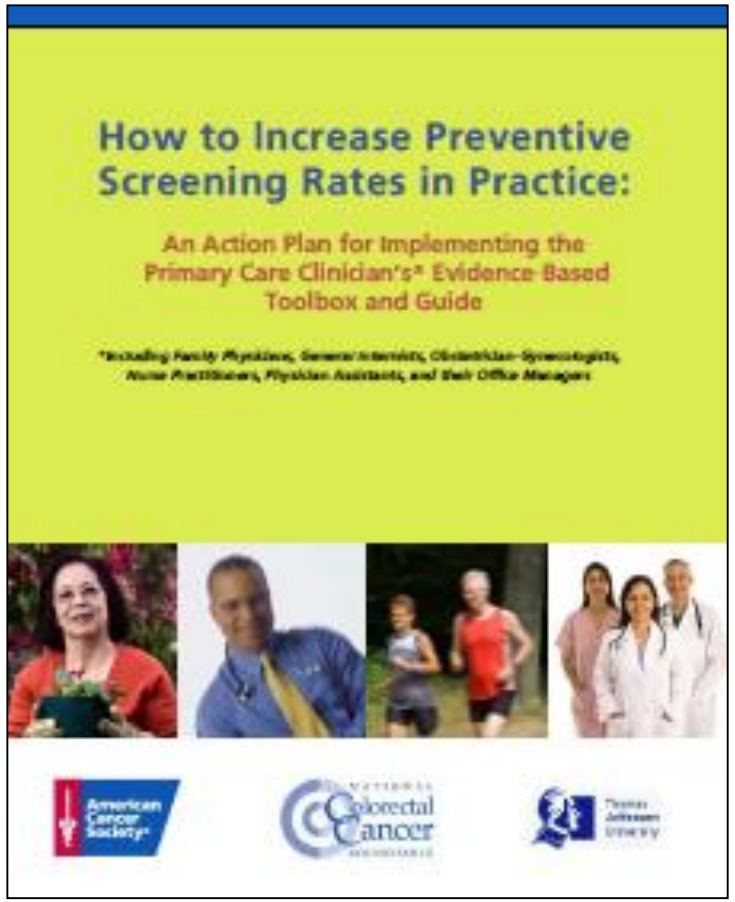
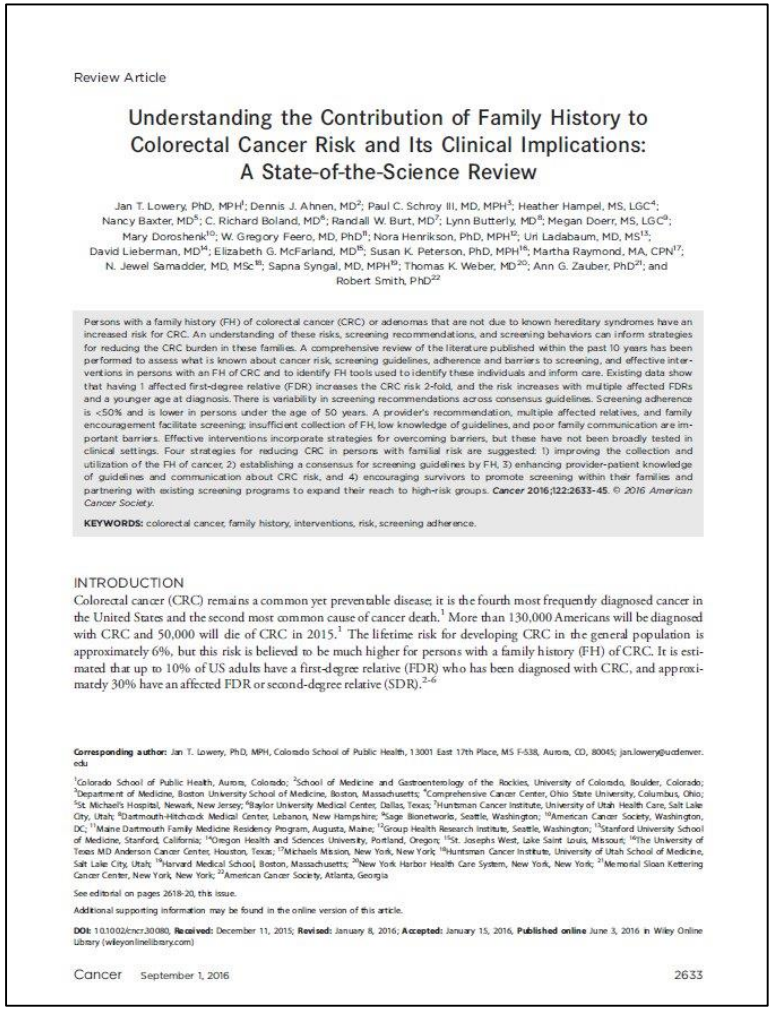
# A Toolkit to Increase Screening Rates in Your Practice

- This 8 page guide introduces clinicians and staff to concepts and tools provided in the full Toolkit
- Contains links to the full Toolkit, tools and resources
- ***Not colorectal-specific***; practical, action-oriented assistance that can be used in the office to improve screening rates for multiple cancer sites (colorectal, breast and cervical)




**Available at http://nccrt.org/about/provider-education/crc-clinician-guide/**

# Workshops



Review Article

## Understanding the Contribution of Family History to Colorectal Cancer Risk and Its Clinical Implications: A State-of-the-Science Review

Jan T. Lowery, PhD, MPH[1]; Dennis J. Ahnen, MD[2]; Paul C. Schroy III, MD, MPH[3]; Heather Hampel, MS, LGC[4]; Nancy Baxter, MD[5]; C. Richard Boland, MD[6]; Randall W. Burt, MD[7]; Lynn Butterly, MD[8]; Megan Doerr, MS, LGC[9]; Mary Doroshenk[10]; W. Gregory Feero, MD, PhD[11]; Nora Henrikson, PhD, MPH[12]; Uri Ladabaum, MD, MS[13]; David Lieberman, MD[14]; Elizabeth G. McFarland, MD[15]; Susan K. Peterson, PhD, MPH[16]; Martha Raymond, MA, CPN[17]; N. Jewel Samadder, MD, MSc[18]; Sapna Syngal, MD, MPH[19]; Thomas K. Weber, MD[20]; Ann G. Zauber, PhD[21]; and Robert Smith, PhD[22]

Persons with a family history (FH) of colorectal cancer (CRC) or adenomas that are not due to known hereditary syndromes have an increased risk for CRC. An understanding of these risks, screening recommendations, and screening behaviors can inform strategies for reducing the CRC burden in these families. A comprehensive review of the literature published within the past 10 years has been performed to assess what is known about cancer risk, screening guidelines, adherence and barriers to screening, and effective interventions in persons with an FH of CRC and to identify FH tools used to identify these individuals and inform care. Existing data show that having 1 affected first-degree relative (FDR) increases the CRC risk 2-fold, and the risk increases with multiple affected FDRs and a younger age at diagnosis. There is variability in screening recommendations across consensus guidelines. Screening adherence is <50% and is lower in persons under the age of 50 years. A provider's recommendation, multiple affected relatives, and family encouragement facilitate screening; insufficient collection of FH, low knowledge of guidelines, and poor family communication are important barriers. Effective interventions incorporate strategies for overcoming barriers, but these have not been broadly tested in clinical settings. Four strategies for reducing CRC in persons with familial risk are suggested: 1) improving the collection and utilization of the FH of cancer, 2) establishing a consensus for screening guidelines by FH, 3) enhancing provider-patient knowledge of guidelines and communication about CRC risk, and 4) encouraging survivors to promote screening within their families and partnering with existing screening programs to expand their reach to high-risk groups. **Cancer 2016;122:2633-45.** © *2016 American Cancer Society.*

**KEYWORDS:** colorectal cancer, family history, interventions, risk, screening adherence.

INTRODUCTION

Colorectal cancer (CRC) remains a common yet preventable disease; it is the fourth most frequently diagnosed cancer in the United States and the second most common cause of cancer death.[1] More than 130,000 Americans will be diagnosed with CRC and 50,000 will die of CRC in 2015.[1] The lifetime risk for developing CRC in the general population is approximately 6%, but this risk is believed to be much higher for persons with a family history (FH) of CRC. It is estimated that up to 10% of US adults have a first-degree relative (FDR) who has been diagnosed with CRC, and approximately 30% have an affected FDR or second-degree relative (SDR).[2-6]

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See editorial on pages 2618-20, this issue.

Additional supporting information may be found in the online version of this article.

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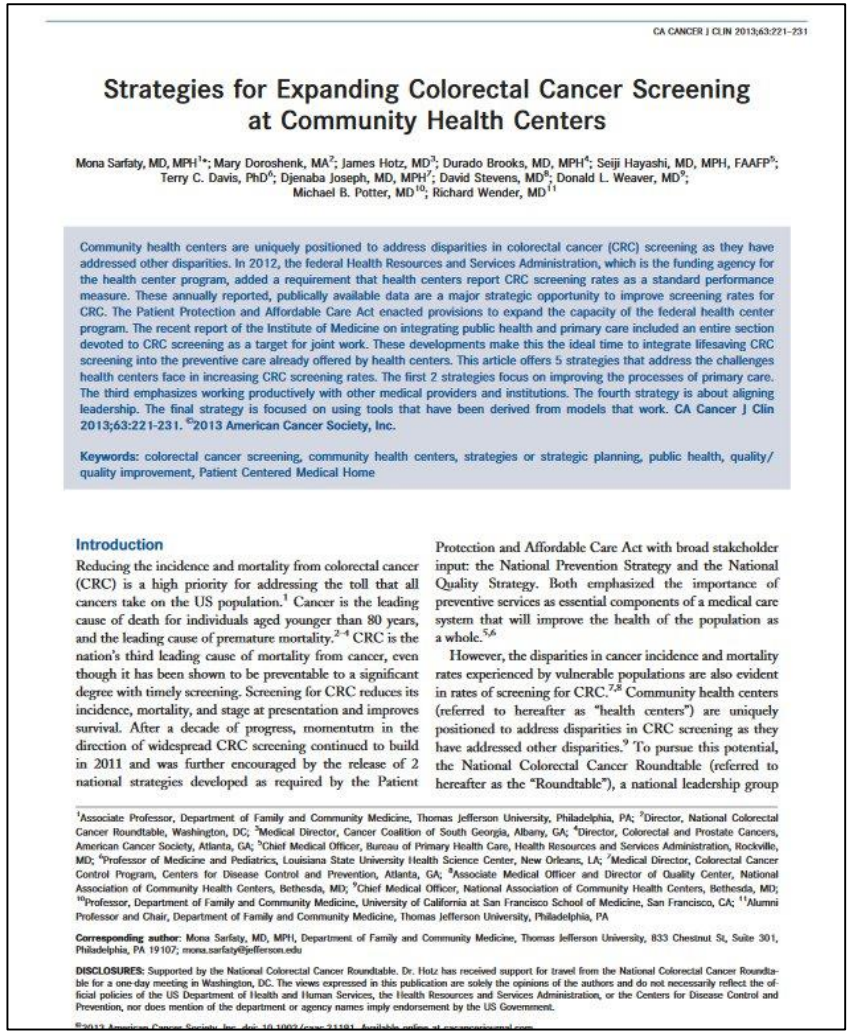

CA CANCER J CLIN 2013;63:221–231

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

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

Community health centers are uniquely positioned to address disparities in colorectal cancer (CRC) screening as they have addressed other disparities. In 2012, the federal Health Resources and Services Administration, which is the funding agency for the health center program, added a requirement that health centers report CRC screening rates as a standard performance measure. These annually reported, publically available data are a major strategic opportunity to improve screening rates for CRC. The Patient Protection and Affordable Care Act enacted provisions to expand the capacity of the federal health center program. The recent report of the Institute of Medicine on integrating public health and primary care included an entire section devoted to CRC screening as a target for joint work. These developments make this the ideal time to integrate lifesaving CRC screening into the preventive care already offered by health centers. This article offers 5 strategies that address the challenges health centers face in increasing CRC screening rates. The first 2 strategies focus on improving the processes of primary care. The third emphasizes working productively with other medical providers and institutions. The fourth strategy is about aligning leadership. The final strategy is focused on using tools that have been derived from models that work. **CA Cancer J Clin 2013;63:221-231.** ©2013 American Cancer Society, Inc.

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

### Introduction

Reducing the incidence and mortality from colorectal cancer (CRC) is a high priority for addressing the toll that all cancers take on the US population.[1] Cancer is the leading cause of death for individuals aged younger than 80 years, and the leading cause of premature mortality.[2-4] CRC is the nation's third leading cause of mortality from cancer, even though it has been shown to be preventable to a significant degree with timely screening. Screening for CRC reduces its incidence, mortality, and stage at presentation and improves survival. After a decade of progress, momentutm in the direction of widespread CRC screening continued to build in 2011 and was further encouraged by the release of 2 national strategies developed as required by the Patient Protection and Affordable Care Act with broad stakeholder input: the National Prevention Strategy and the National Quality Strategy. Both emphasized the importance of preventive services as essential components of a medical care system that will improve the health of the population as a whole.[5,6]

However, the disparities in cancer incidence and mortality rates experienced by vulnerable populations are also evident in rates of screening for CRC.[7,8] Community health centers (referred to hereafter as "health centers") are uniquely positioned to address disparities in CRC screening as they have addressed other disparities.[9] To pursue this potential, the National Colorectal Cancer Roundtable (referred to hereafter as the "Roundtable"), a national leadership group

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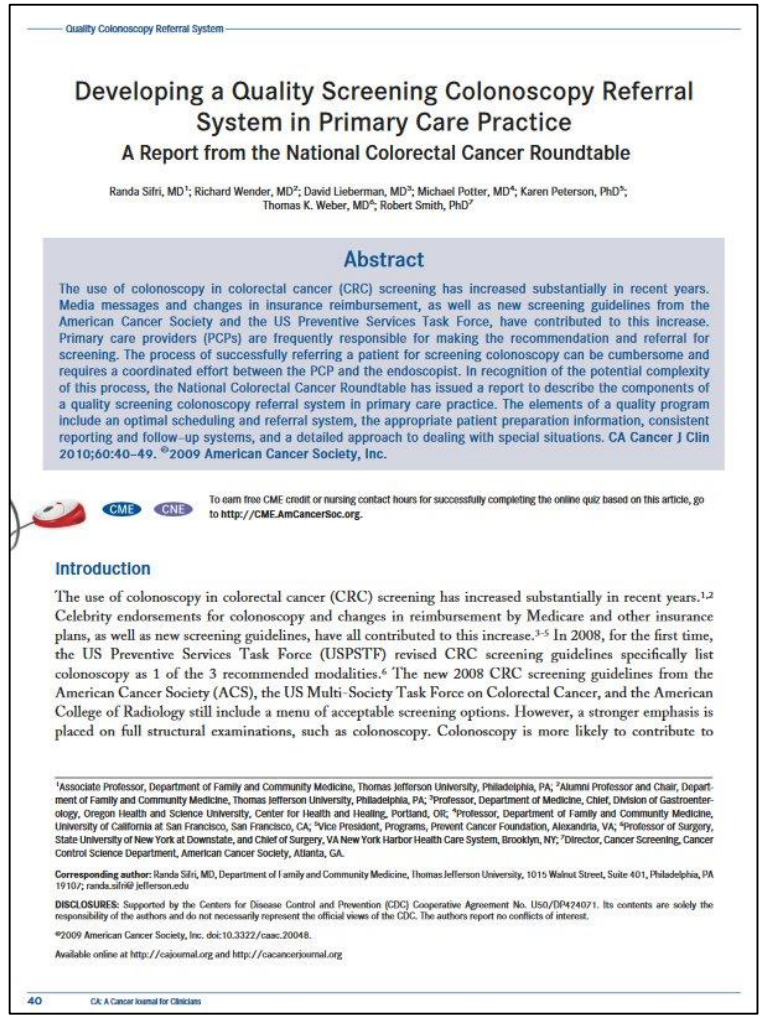



## Developing a Quality Screening Colonoscopy Referral System in Primary Care Practice

### A Report from the National Colorectal Cancer Roundtable

Randa Sifri, MD[1]; Richard Wender, MD[2]; David Lieberman, MD[3]; Michael Potter, MD[4]; Karen Peterson, PhD[5]; Thomas K. Weber, MD[6]; Robert Smith, PhD[7]

### Abstract

The use of colonoscopy in colorectal cancer (CRC) screening has increased substantially in recent years. Media messages and changes in insurance reimbursement, as well as new screening guidelines from the American Cancer Society and the US Preventive Services Task Force, have contributed to this increase. Primary care providers (PCPs) are frequently responsible for making the recommendation and referral for screening. The process of successfully referring a patient for screening colonoscopy can be cumbersome and requires a coordinated effort between the PCP and the endoscopist. In recognition of the potential complexity of this process, the National Colorectal Cancer Roundtable has issued a report to describe the components of a quality screening colonoscopy referral system in primary care practice. The elements of a quality program include an optimal scheduling and referral system, the appropriate patient preparation information, consistent reporting and follow-up systems, and a detailed approach to dealing with special situations. **CA Cancer J Clin 2010;60:40-49.** ©2009 American Cancer Society, Inc.

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### Introduction

The use of colonoscopy in colorectal cancer (CRC) screening has increased substantially in recent years.[1,2] Celebrity endorsements for colonoscopy and changes in reimbursement by Medicare and other insurance plans, as well as new screening guidelines, have all contributed to this increase.[3-5] In 2008, for the first time, the US Preventive Services Task Force (USPSTF) revised CRC screening guidelines specifically list colonoscopy as 1 of the 3 recommended modalities.[6] The new 2008 CRC screening guidelines from the American Cancer Society (ACS), the US Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology still include a menu of acceptable screening options. However, a stronger emphasis is placed on full structural examinations, such as colonoscopy. Colonoscopy is more likely to contribute to

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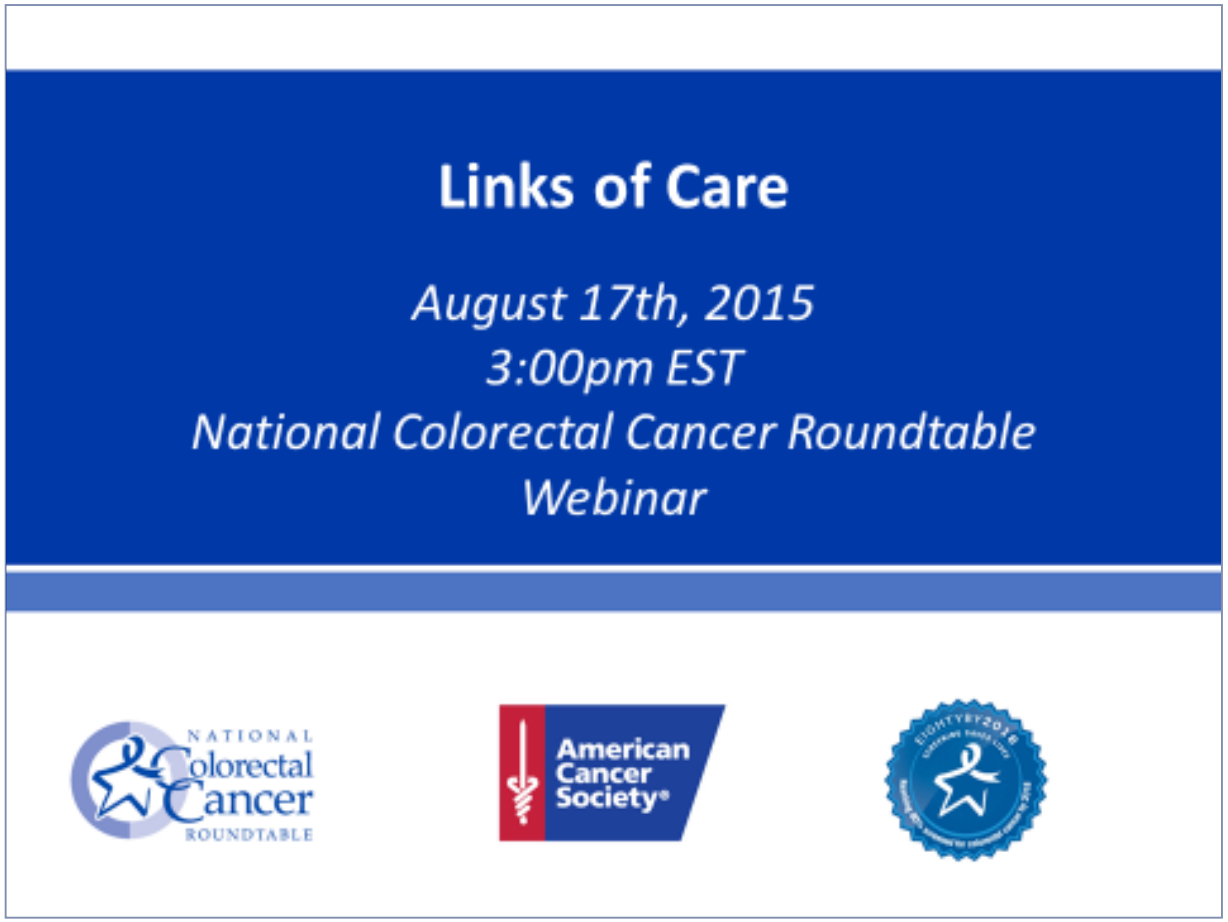
Available online at http://cajournal.org and http://cacancerjournal.org

# *Links of Care* Pilots could be adapted to lung cancer screening




Primary goal:

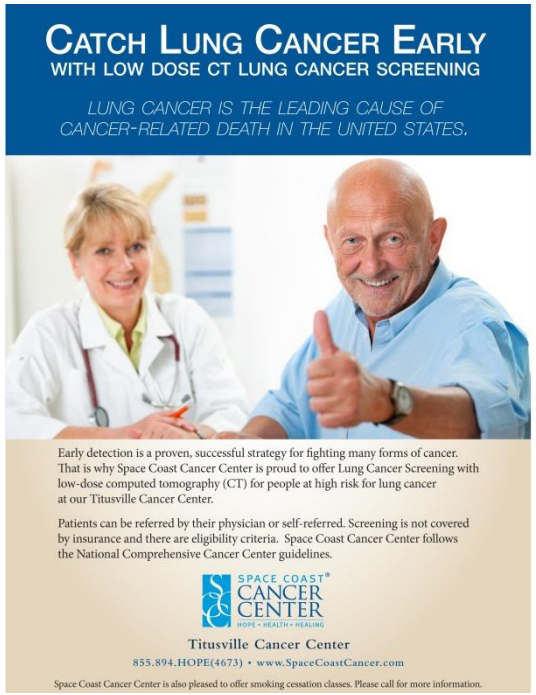
- Increase timely access to specialists for FQHC patients after a positive colorectal cancer screening result.

Key characteristics:

- Physician champion
- Defined capacity
- Shared burden
- Care coordination/ documented workflows
- Screening navigation
- Shared credit

# State-Level Engagement—We will achieve more if we engage with State Systems

# Current Status of LDCT Screening in the U.S.— Access to Care is a High Priority






- The USPSTF "B" rating means that the Affordable Care Act requires coverage of lung cancer screening with no out-of-pocket costs

  CMS also covers LDCT screening and the shared decision making visit

GROUPON | Featured Deal | All Deals | Getaways | Goods | Vacation Time | Gifts

All Deals | New Deals | Food & Drink | Events & Activities | Beauty & Spa | Fitness | Health | Home & Auto | Shopping

# Virtual Imaging, Inc. – Perimeter Center

Heart Scan and Consultation with Option for Lung Scan (Up to 96% Off)

from $19 **Buy!**

| Value | Discount | You Save |
|---|---|---|
| $499 | 96% | $480 |

Give as a Gift

Learn more

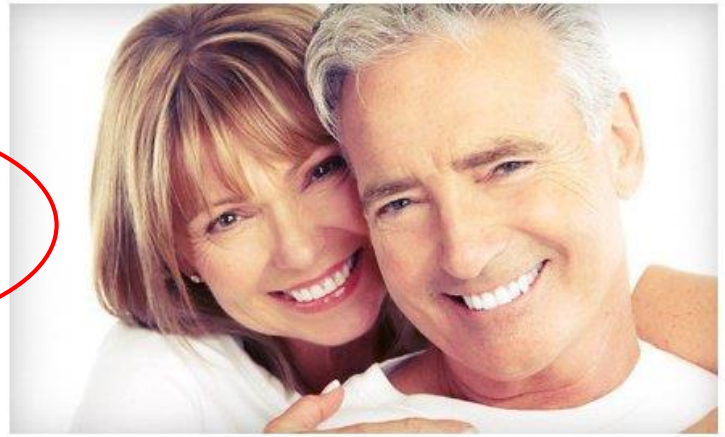
**Limited time remaining!**

**Over 1,000 bought**

**Limited quantity available**

**The deal is on!**

Send | Like 66 | Mail | Tweet | Pin it



## In a Nutshell

Advanced CT scanner obtains diagnostic images that can show internal warning signs and help patients thwart major disease and illness

## The Fine Print

Expires 180 days after purchase. Limit 2 per person, may buy multiple additional as gifts. Must book appointment within 90 days of purchase. Valid only for option purchased. Appointment required. Not valid for patients with metallic implants, including pacemakers and splints as they may affect test results. Must be between 45 and 72 years old. Must be under under 6'4". Max weight 320 lbs. Married couples must redeem at the same time.

See the rules that apply to all deals.

# We Face a Long List of Challenges

- Avoid reinventing the wheels
- Develop resources
- Stimulate new knowledge and best practices
- Policy issues loom large (specifically, coverage)
- Quality issues are paramount
- Change the “mindset” about lung cancer to reduce stigma and nihilism
- Monitor our influence, Seek to do better

# What is your role?

- Roundtables succeed through member engagement
- Get involved! Communicate!
- You are your organization's ambassador—keep them informed, and *get them involved*
- ***Thank you***