



Engage Authentically with Community

Community members should have an **equal place** and **equal voice** wherever decisions are being made that will ultimately impact them

Share What We Know

Let's shout from the
rooftops - together!



Foster Partnerships

“Whole-of-community”
approach to address and
improve the conditions that
create health



Equity Call to Action

- Show commitment - Walk the talk
- Train and invest in your employees
- Let data and community voices be your guide
- Share what you know
- It takes all of us



Comprehensive Cancer
Alliance for Idaho

Thank You

Katie Lamansky, CHES
Health Program Manager

Get Healthy Idaho

Bureau of Equity & Strategic Partnerships

Division of Public Health

Idaho Dept of Health & Welfare

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The Power of Partnership in Advancing Health Equity

DR. DAVID W. WETTER, PH.D.

**Director of the Center for (HOPE)
Health Outcomes and Population Equity**

The Power of Partnerships in Advancing Health Equity

David W. Wetter, Ph.D.

Jon M. and Karen Huntsman Presidential Professor
Director, Center for Health Outcomes and Population Equity (HOPE)
Associate Director, Practice Engagement and Translation at CTSI
Huntsman Cancer Institute and the University of Utah

Center for HOPE

(Health Outcomes and Population Equity)

<https://uofuhealth.utah.edu/huntsman/labs/center-for-hope/>

CENTER FOR HOPE
HEALTH OUTCOMES & POPULATION EQUITY

UNIVERSITY OF UTAH
HUNTSMAN
CANCER INSTITUTE

CCAI
Comprehensive Cancer
Alliance for Idaho

U HEALTH
UNIVERSITY OF UTAH

Center for HOPE Mission and Vision

Mission: Bring communities and researchers together to **create long-term solutions** to prevent and control cancer, chronic and infectious disease, and improve health among underserved populations.

Vision: Equity in disease incidence, morbidity, and mortality in Utah and the Mountain West.



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Who We Are: A **research infrastructure** and bridge between scientists and community organizations (e.g., health care, government, education, nonprofits, faith based, social services, tribal) throughout Utah and the Mountain West. We utilize **strategic focused partnering for community engagement, sustainability, and population impact.**

Training Mission

- Train scientists to address health inequities and social justice



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Ensuring Health Equity in the Implementation of Evidence-Based Interventions

- **Non-targeted programs and interventions negatively impact health equity, but targeted programs can reduce inequities**
(Hill et al., Tobacco Control, 2014; Brown et al., DAD, 2014; Hiscock et al., Ann NY Acad Sci, 2012)
- **Our Goal:** Create behavioral and digital health tools and approaches (EHR, telehealth, mHealth, behavioral, health communications) specifically targeted at improving health and wellness in populations that have been historically marginalized and low resource settings

Partnering to Reach Health Equity Populations

14 Utah Community Health Centers operate
~50 primary care clinics and serve **> 160,000 individuals**

Racially/Ethnically Diverse

- 50% Hispanic/Latino Ethnicity
- 8% American Indian/Alaska Native
- 38% Best served in a language other than English

Low Socioeconomic Status

- 61% < Federal Poverty Level
- 45% Uninsured

Rural/Frontier

- 41% of clinics in rural/frontier areas (RUCC ≥ 4)

CENTER FOR HOPE
HEALTH OUTCOMES & POPULATION EQUITY

 **AUCH**
ASSOCIATION FOR UTAH COMMUNITY HEALTH

14
Community Health Centers



 Utah Department of
Health & Human
Services

UNIVERSITY OF UTAH
HUNTSMAN
CANCER INSTITUTE

 **HEALTH**
UNIVERSITY OF UTAH

Building Together in Utah

Funded Projects

- QuitSMART Utah (PCORI Pragmatic Trial) \$9.5M
- Colorectal Cancer Screening (CDC) ~\$3.5M
- BeatPain Utah (NINR) ~\$3M
- HPV Vaccination (ACS) ~\$900K
- Health Information Technology (HRSA), AUCH, \$520K
- SCALE-UP UTAH I (RADxUP NCATS) ~\$5M
- SCALE-UP UTAH II (RADxUP NCATS) ~\$2.3M

CENTER FOR HOPE
HEALTH OUTCOMES & POPULATION EQUITY



AUCH

ASSOCIATION FOR UTAH COMMUNITY HEALTH

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**Community
Health Centers**



Utah Department of
**Health & Human
Services**

CENTER FOR HOPE
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- SCALE-UP Counts (RADxUP NICHD) ~\$2.4M
- Grand Challenges/Intermountain \$200K
- Medicaid DPP/Lifestyle Change (Marigold) ~\$150K

CENTER FOR HOPE
HEALTH OUTCOMES & POPULATION EQUITY



AUCH

ASSOCIATION FOR UTAH COMMUNITY HEALTH

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Community Health Centers



Utah Department of
Health & Human Services

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Pending

- Community Partnerships to Advance Science for Society (NIH) \$11.6M



14

**Community
Health Centers**



Taking Interventions to Scale



QuitSMART Utah

SMART Randomized Clinical Trial (Target N=6,000)

- 10 Community Health Center Systems (33 clinics)
- Enrolled >11,500 low SES tobacco users to date

Taking Interventions to Scale



QuitSMART Utah

Grand Challenges with Intermountain Healthcare

SMART Randomized Clinical Trial (Target N=6,000)

- 10 Community Health Center Systems (33 clinics)
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Stepped Wedge with Clinic Randomization to Wedges and “Nudge” within Wedges (Target N=40 clinics)

- Implemented in 125 Clinics in 5 wedges
- Anticipate screening ~500,000 patients for tobacco use (~20% of the adult population in Utah)
- Have screened >415,000 patients to date

Taking Interventions to Scale



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HEALTH OUTCOMES & POPULATION EQUITY

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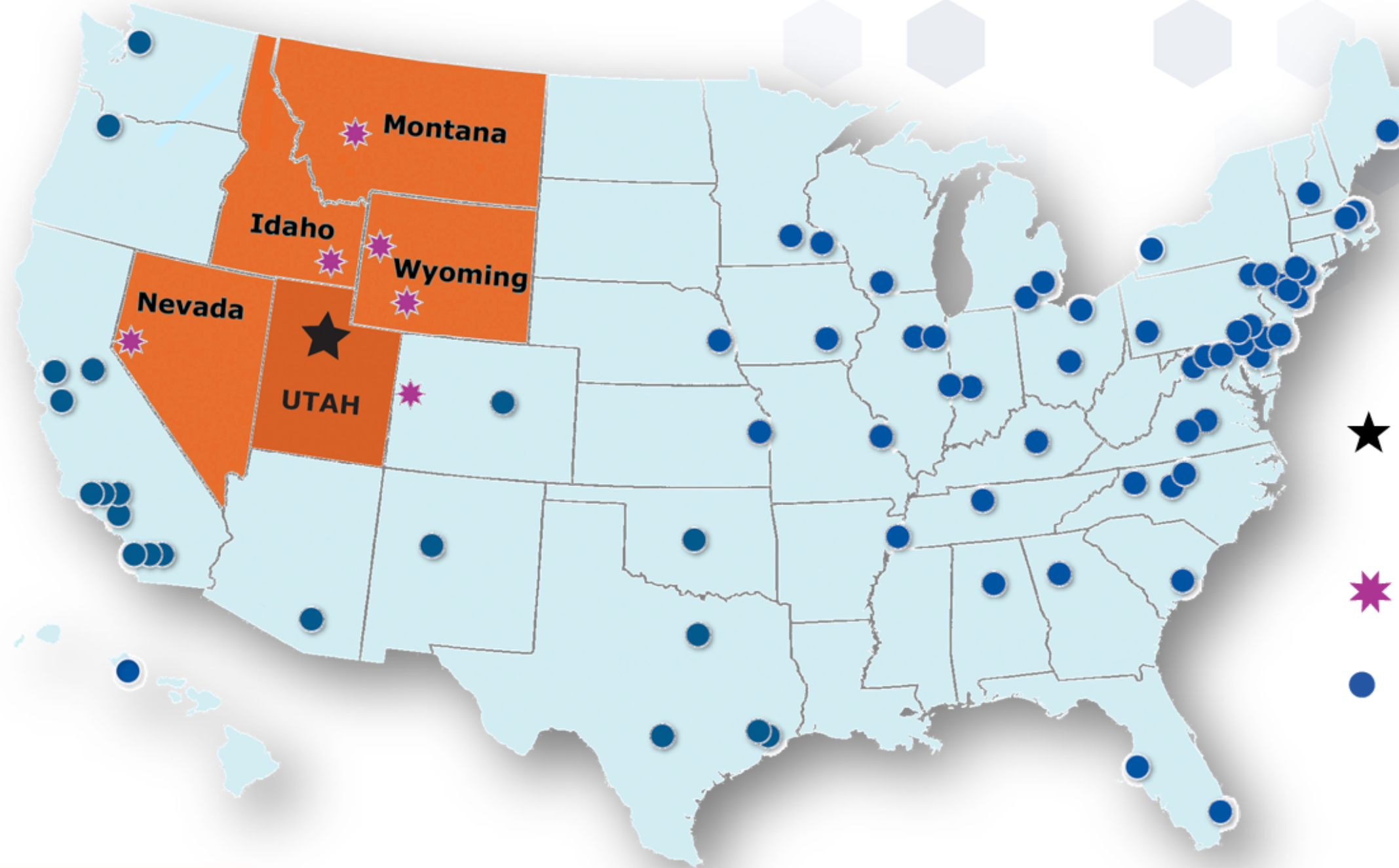
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Randomized Clinical Trial

- Reached ~110,000 diverse, low SES, and rural patients with COVID-19 messaging
- 40% Latino; 30% of all messaging in Spanish
- 37 different message workflows across 227 different cohorts
- 32% engaged in “conversation”

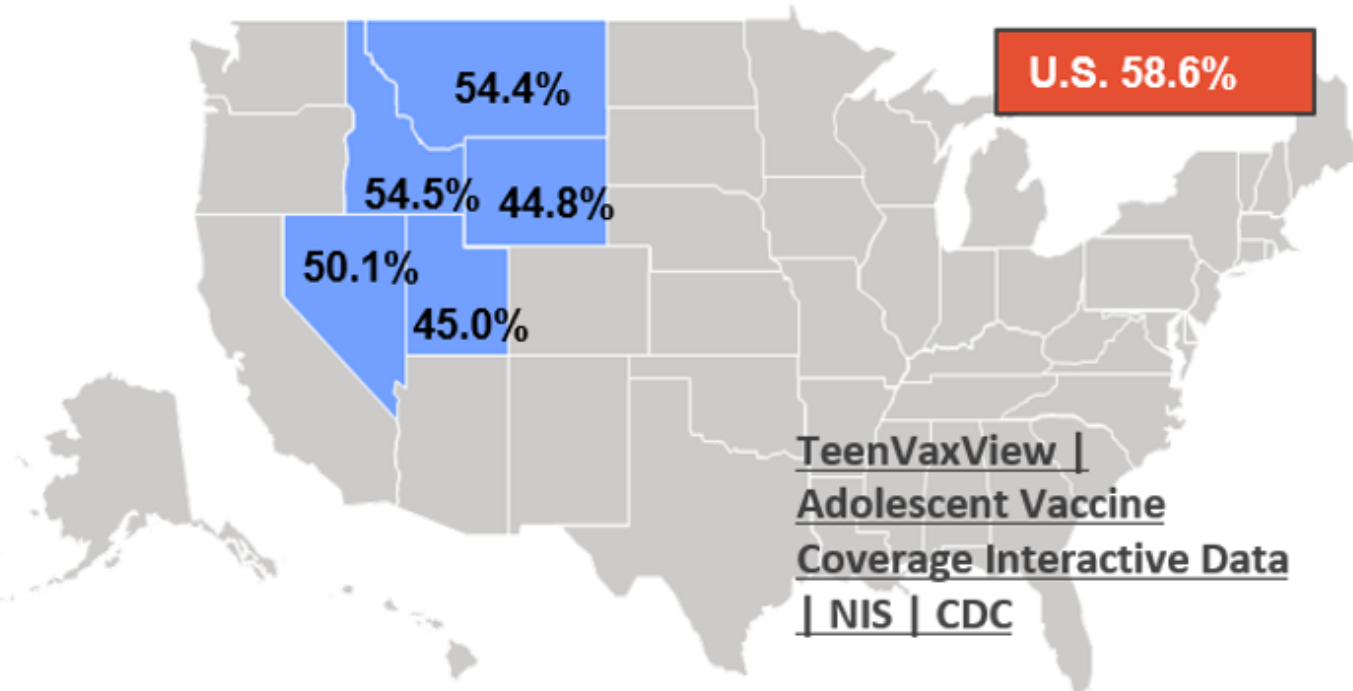
Expanding the Area We Serve to the Mountain West



- ★ Four HCI Locations
- ✳ HCI Affiliates
- NCI-Designated Cancer Centers

Developing Partnerships In the Mountain West

Mountain West States HPV Vaccination Rates

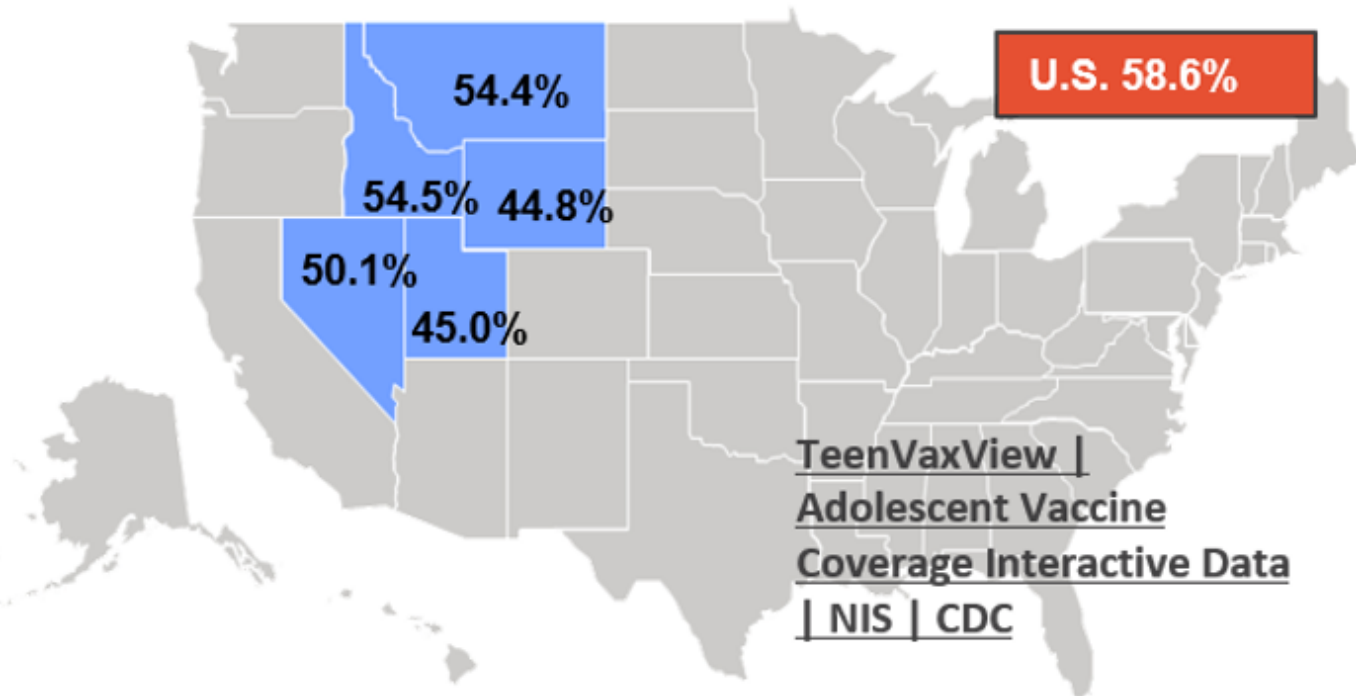


Mountain West HPV Vaccination Project

- Five States (UT, ID, MT, WY, NV)
- Consortium and small state meetings
- Health Information Technology EBI implementation
- ECHO series

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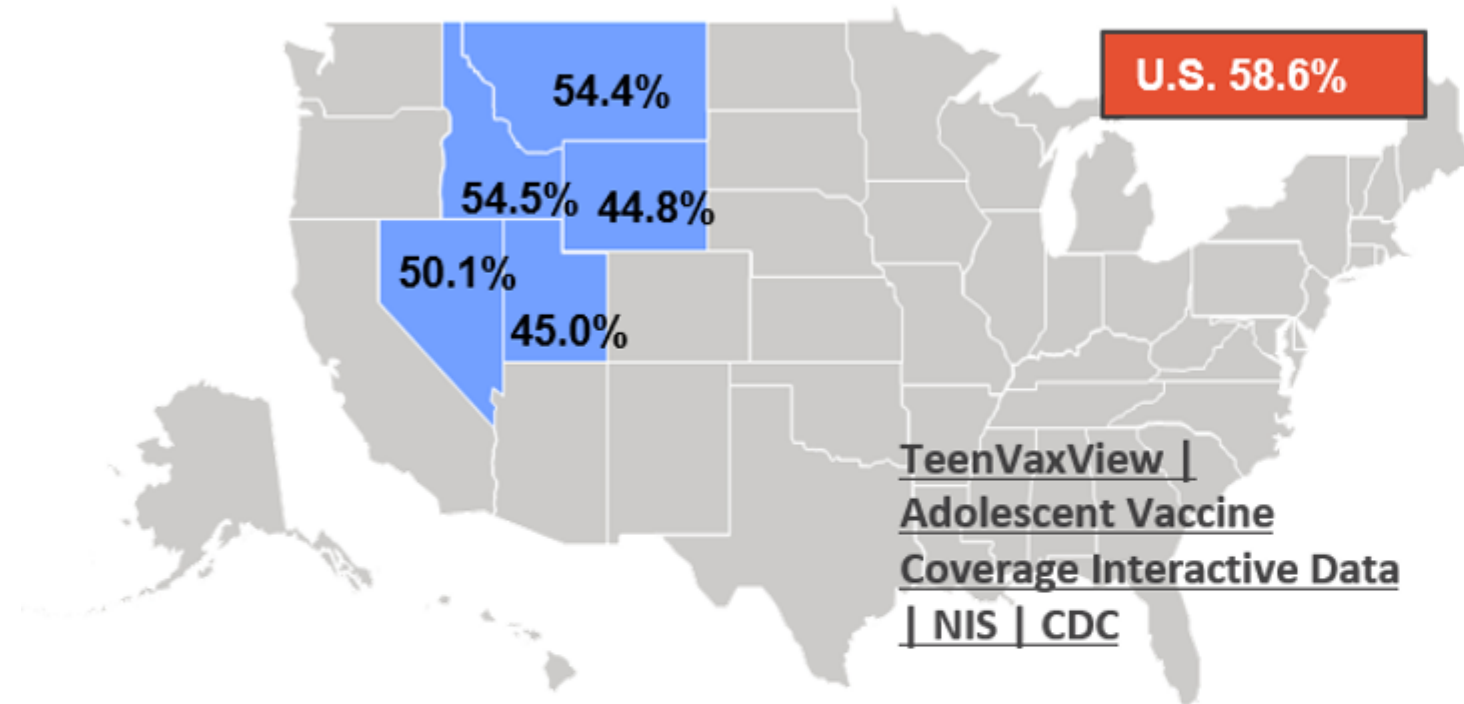
Survivorship in Montana oneHealth CHC

FQHC with 8 sites over 6 counties

- 5 sites with highest RUCC and RUCA codes
- Over 9,000 patients served annually
- 25% of patients are American Indian/Alaska Native

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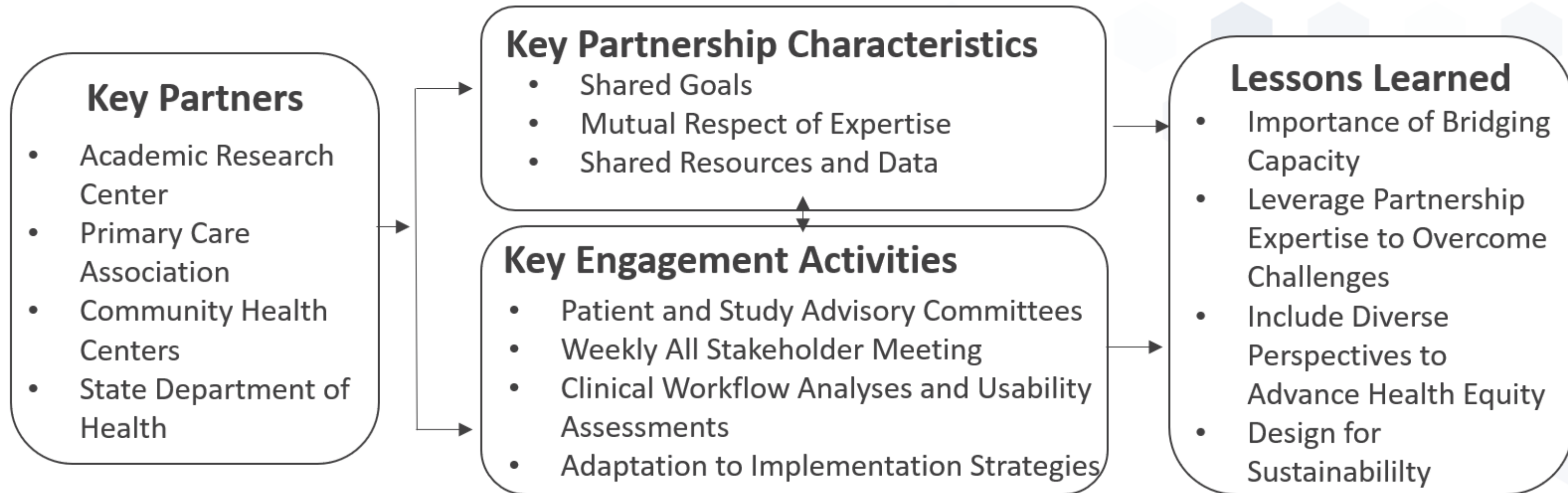
- 5 sites with highest RUCC and RUCA codes
- Over 9,000 patients served annually
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Implementing Ask-Advise-Connect in Nevada Southern Nevada CHC

Urban setting

- Over 6,700 patients served annually
- 79% of patients are racial/ethnic minority
- 88% of patients at/or below 200% of poverty

Community-Engaged Dissemination and Implementation Research



Schlechter, C. R. et al. Application of Community – Engaged Dissemination and Implementation Research to Improve Health Equity. (Preventive Medicine Reports, 2021)

Community-Engaged Dissemination and Implementation Research



Schlechter, C. R. et al. Application of Community – Engaged Dissemination and Implementation Research to Improve Health Equity. (Preventive Medicine Reports, 2021)

Partnership Characteristics

- **Shared Goals**
 - Driven by **priorities of our community partners**
- **Mutual Respect of Expertise**
 - **Patient and Study Advisory Committees**
 - **Weekly All Stakeholder Meeting**
 - **Primary Care Association team member embedded at the Center for HOPE**



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 - **Primary Care Association team member embedded at the Center for HOPE**
- **Shared Resources and Data**
 - All projects include **bidirectional communication**
 - Utah Department of Health has **shifted funding and provided resources/data to create synergy with the funded research projects** (e.g., providing tobacco cessation medications for uninsured; identifying COVID hotspots to target)
 - Projects **provide funding to partners** (e.g., ~\$2.5M to AUCH to tie together Utah's 13 CHCs via a Population Health Management tool; ~\$1.5M to CHCs for implementation of tobacco cessation health information technology)

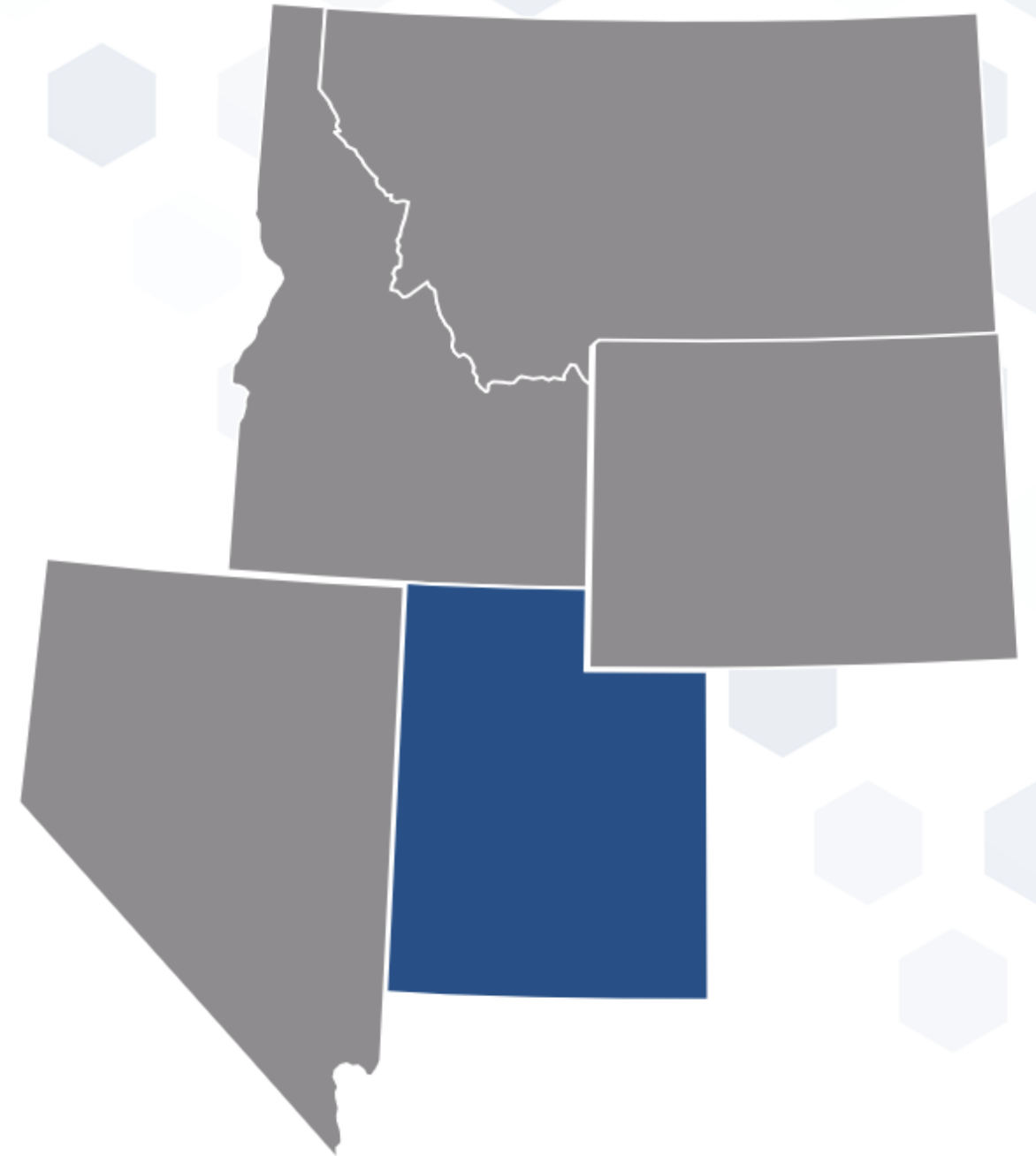


Designing for Sustainability

- **Digital Health as a Foundation (huge proportion of EBIs are technology-based)**
 - Work with CHC EHRs and EHR vendors to create disseminable solutions
 - Population Health Management tools tie CHC systems together to identify patient cohorts and disseminate interventions (e.g., texting, navigation, chatbots)
 - Digital health interventions have to be targeted to low resource settings and communities that have been historically marginalized to avoid exacerbating health inequities
- **Community Health Workers/Health Educators/Patient Navigators**
 - Utilize Community Health Workers from existing organizations (e.g., AUCH)
- **Utilize Existing Evidence-Based Interventions (EBIs)/Resources**
 - Primary prevention utilizes existing EBIs (e.g., Tobacco Quitlines, Diabetes Prevention Programs)
 - Screening/testing/vaccination collaborate with state programs (e.g., colorectal, breast and cervical, COVID, HPV)

Looking Ahead

- **Continue to expand/integrate digital health/telehealth portfolio**
- **Expand partnerships**
 - Academic institutions in the Mountain West
 - CHCs, primary care associations, and state health programs in the Mountain West
 - Rural clinics, free clinics, migrant health centers
 - UHealth Clinics, UHealth Affiliates, Intermountain Healthcare, and other Mountain West healthcare systems
 - Medicaid, Quitlines, Diabetes Prevention Programs
- **Design, implement, and evaluate interventions for broad scale implementation/dissemination**





Comprehensive Cancer
Alliance for Idaho



COLORECTAL CANCER (CRC)

A PREVENTABLE DISEASE

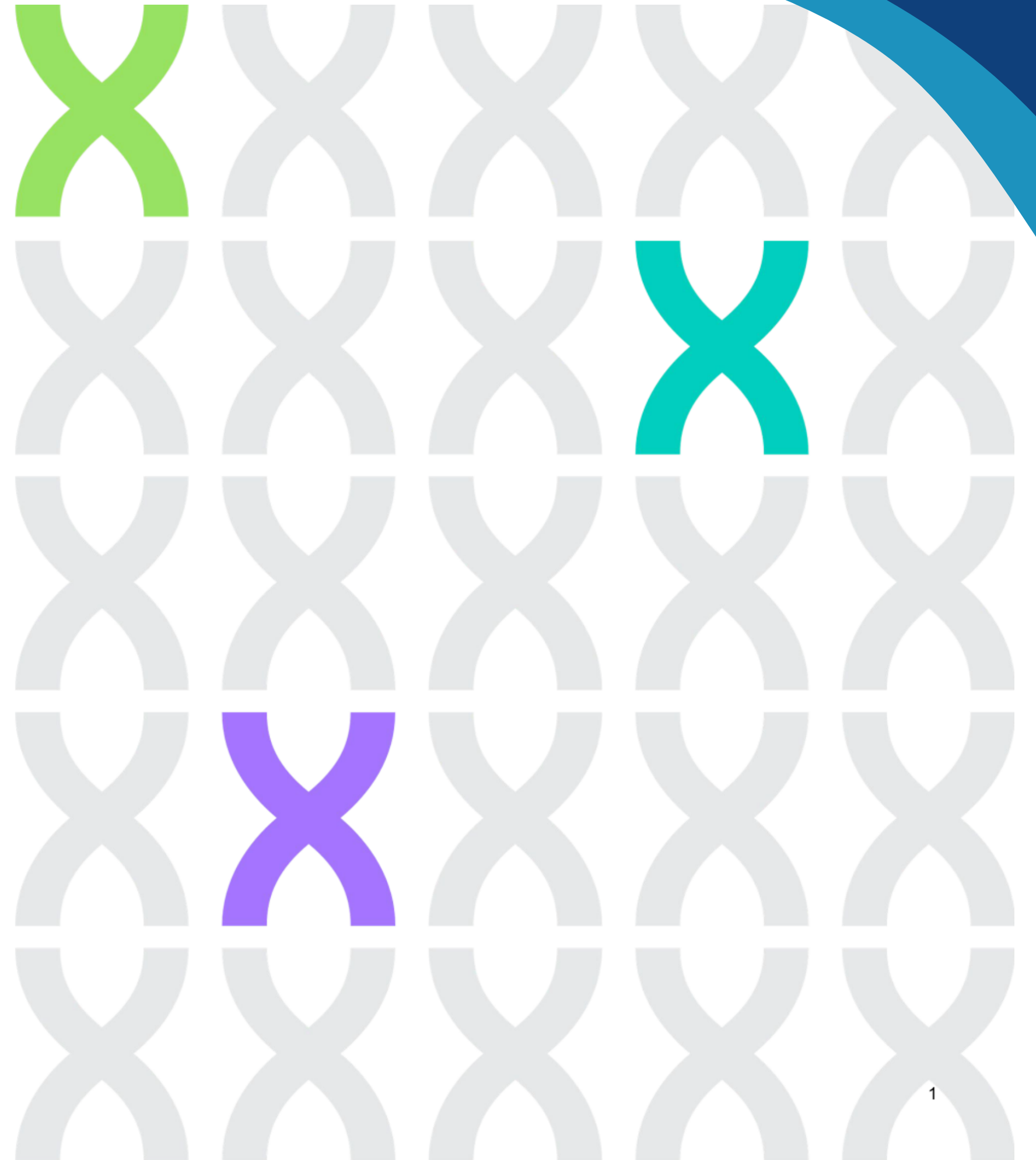
DR. CATHERINE KOUCHAKJI PH.D, MPH

Medical Science Liaison - Exact Sciences

**COLORECTAL
CANCER (CRC)
A PREVENTABLE
DISEASE**

Catherine Kouchakji, PhD, MPH

Feb 23, 2023



COLORECTAL CANCER (CRC) A PREVENTABLE DISEASE

CRC is often considered “the most preventable yet least prevented cancer” ¹

In a retrospective study of patients in the Kaiser Permanente Northern and Southern California systems, 76% of patients who died of CRC between 2006 and 2012, were not up-to-date with screening ²

1. Itzkowitz SH. *J Natl Cancer Inst.* 2009;101(18):1225-1227. doi:10.1093/jnci/djp273.
2. Doubeni KA, et al. *Gastroenterol.* 2019;156:63-74.



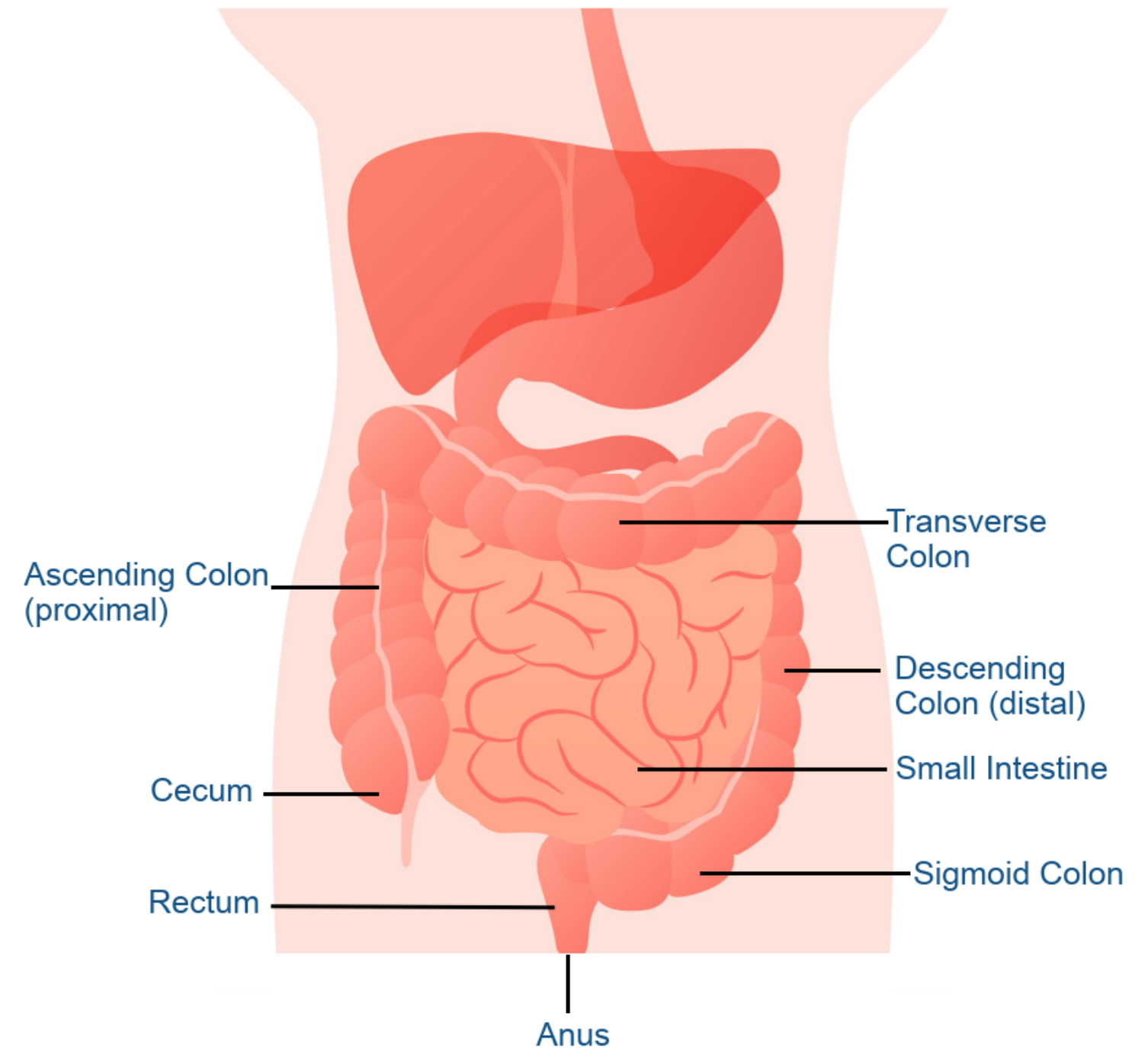
The colorectum comprises the colon and the rectum ¹

Colon

- Function: absorbs water and salt from food; stool is formed in the colon ²
- Anatomy: a muscular tube about 5 ft long (1.5 m) divided into 4 sections (ascending, transverse, descending; sigmoid) ¹

Rectum

- Function: holds stool before it is eliminated from the body ²
- Anatomy: final 6 in (15 cm) of large intestine ¹



American Cancer Society. Colorectal Cancer Facts & Figures 2020-2022. Atlanta: American Cancer Society; 2020. 2. National Cancer Institute. NCI dictionary of cancer terms. <https://www.cancer.gov/publications/dictionaries/cancer-terms/expand/C>. Accessed February 24,

Epidemiology

Risk Factors, Signs, Symptoms

Prevention through Screening

Anatomy

Colorectal Polyp Histopathology

Pathogenesis

Colorectal Polyps (non-cancerous growths in inner lining of colon/rectum)¹

Most colorectal cancers can begin here

Non-neoplastic Lesions^{2,3}

- Benign; not considered cancerous

Neoplastic Lesions (adenomatous)¹⁻³ (adenomas or serrated lesions)

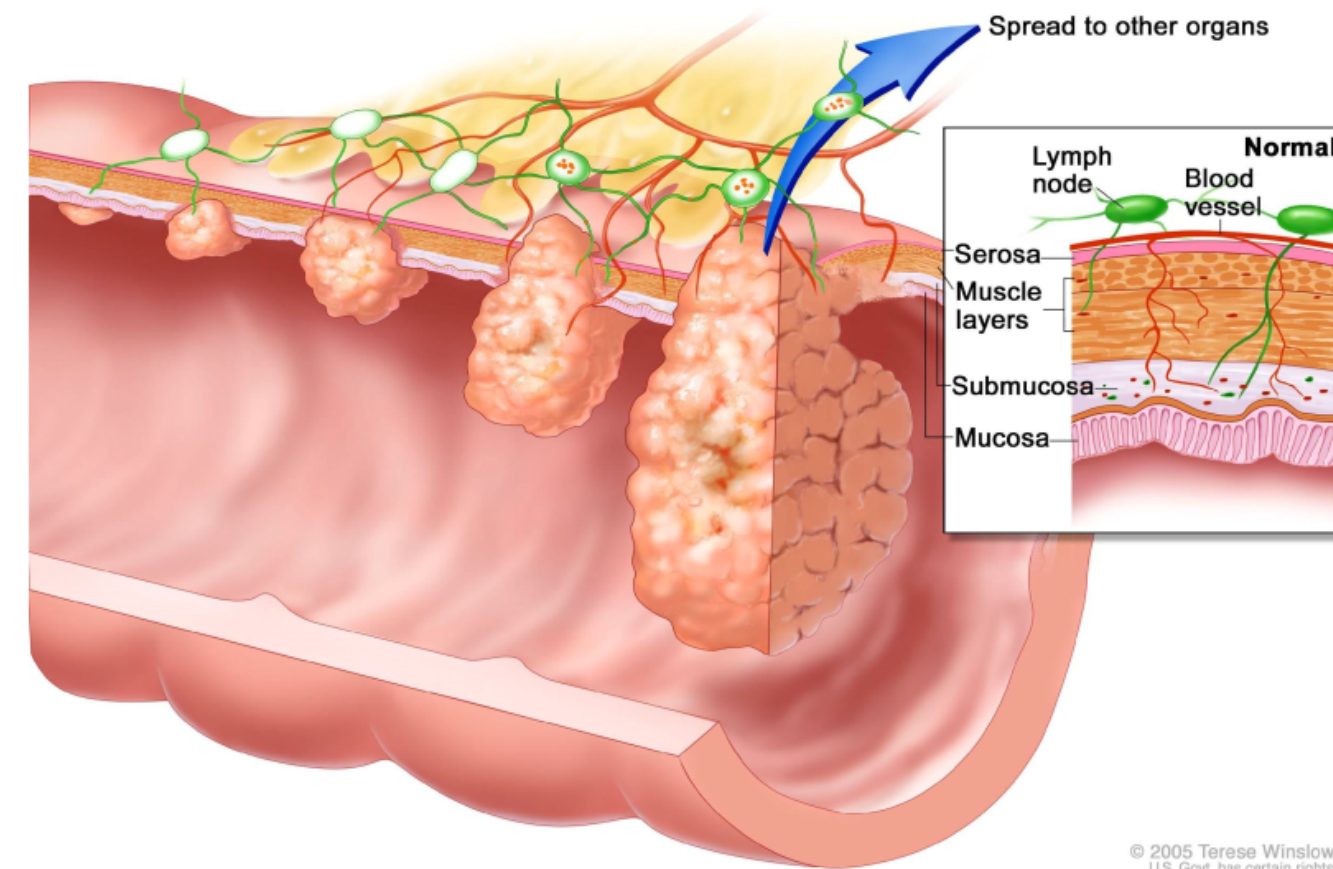
- Have malignant potential (potential to become cancerous)
- Adenomas: may be found anywhere throughout the colon
- Serrated Polyps: usually found in the right side of the colorectum and are more common in females than males.

Colorectal Cancer

1. American Cancer Society. Colorectal Cancer Facts & Figures 2020-2022. Atlanta: American Cancer Society; 2020. 2. Shussman N, Wexner SD. *Gastroenterol Rep (Oxf)*. 2014;2(1):1-15. 3. Gupta S, et al. *Gastrointest Endosc*. 2020;91(3):463-485.e5.

Typical Progression to Early Stage CRC^{1,2}

- Colorectal cancer usually begins as a polyp (Non-cancerous; Stage 0)
 - Note: ~70% of colorectal cancers develop from adenomas
- When a polyp progresses to cancer, it can grow into the wall of the colorectum (Local; Stages 1 and 2)
- It may invade lymph vessels and spread to nearby lymph nodes (Regional; Stage 3)
- Cancer cells may also be carried via blood vessels to other organs such as liver or lung (Distant; Stage 4)
- Progression from adenoma to CRC (>10 yrs)¹



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† Per American Joint Committee on Cancer's (AJCC) staging system: Localized = stage I, IIa, IIb. Regional = stage IIc and III Distant = stage IV.
Rationale: ACS uses localized, regional, and distant. Need to include the cross-walk to AJCC stages
1. Rex DK, et al. *Am J Gastroenterol.* 2017;112(7):1016-1030. 2. American Cancer Society. Colorectal Cancer Facts & Figures 2020-2022. Atlanta: American Cancer Society; 2020. 3. Wolf AMD, et al. *CA Cancer J Clin.* 2018;68(4):250-281. doi:10.3322/caac.21457.

Among all people living in the United States, the five-year survival rate for patients diagnosed with Stage I/II colorectal cancer is 91%.^{2,3*} The five-year survival rate for patients diagnosed with Stage IV cancer is 15%.^{2,3†}

CRC Overview

Epidemiology

Risk Factors, Signs,
Symptoms

Prevention through
Screening

Incidence

Mortality

Age-Related
Trends

COLORECTAL CANCER EPIDEMIOLOGY



- Colorectal cancer is the **third most common** type of newly-diagnosed cancer in **either men or women** in the United States
- It is estimated that there will be 151,030 new cases of colorectal cancer diagnosed in 2022
- The risk of being diagnosed with colorectal cancer varies by a person's race and ethnicity.

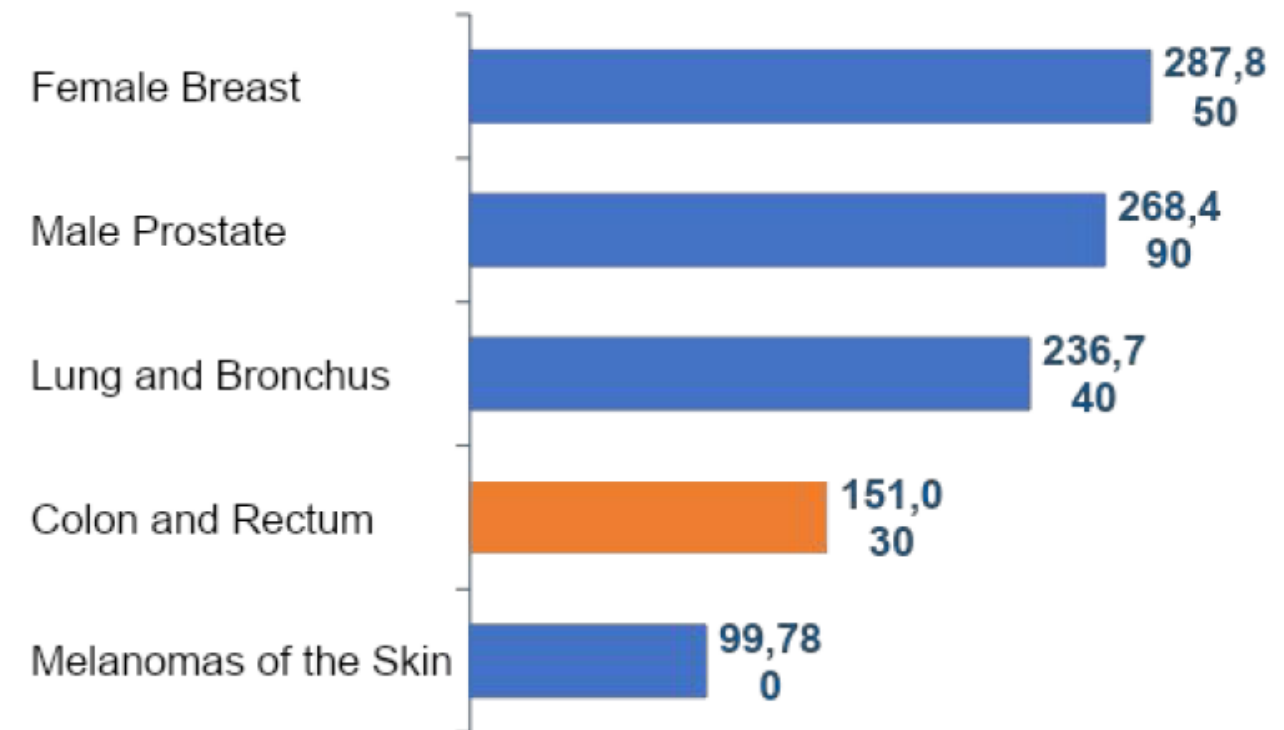
Overall lifetime risk of developing colorectal cancer:



4.2% for males (about 1 in 24)

4.0% for females (about 1 in 25)

Top 5 Cancers by Number of New Cancer Cases (United States, 2022)¹



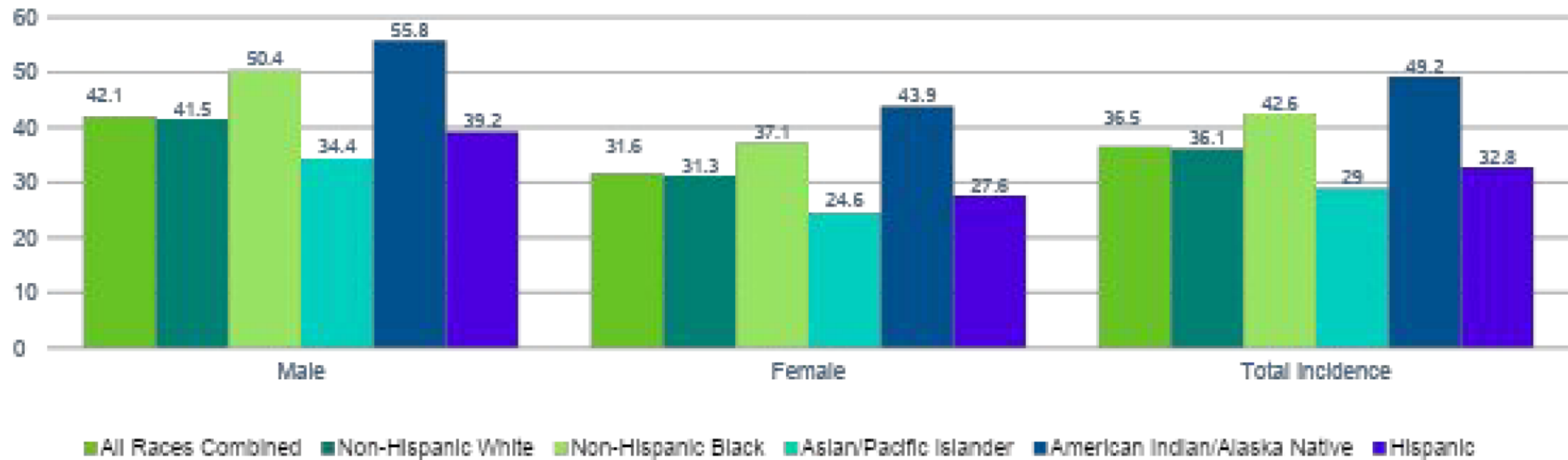
1. Jemal A, Murray T, Samuels A, et al. CA Cancer J Clin. 2022;72(1):7-33. doi:10.3322/caac.21708.

Incidence

Mortality

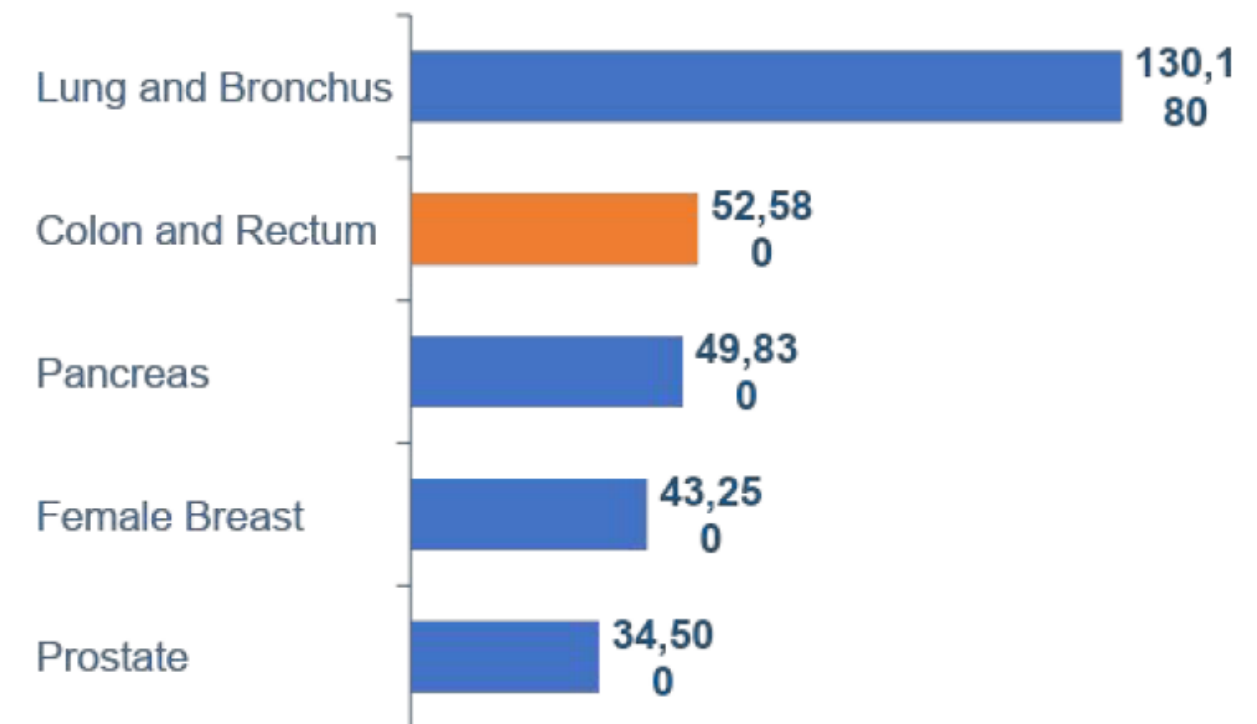
Age-Related
Trends

Incidence of CRC by Race, Ethnicity, and Sex in the United States from 2014-2018
(per 100,000 people)



- Colorectal cancer is the **second leading cause** of cancer-related death in the United States¹
- Five-year survival varies by stage at diagnosis and by a person's race and ethnicity.¹
- Among all people living in the United States, the five-year survival rate for patients diagnosed with Stage I/II colorectal cancer is 91%.^{1,2*} The five-year survival rate for patients diagnosed with Stage IV cancer is 15%.^{1,2†}

Top 5 Cancers by Number of Cancer Deaths (United States, 2022)¹



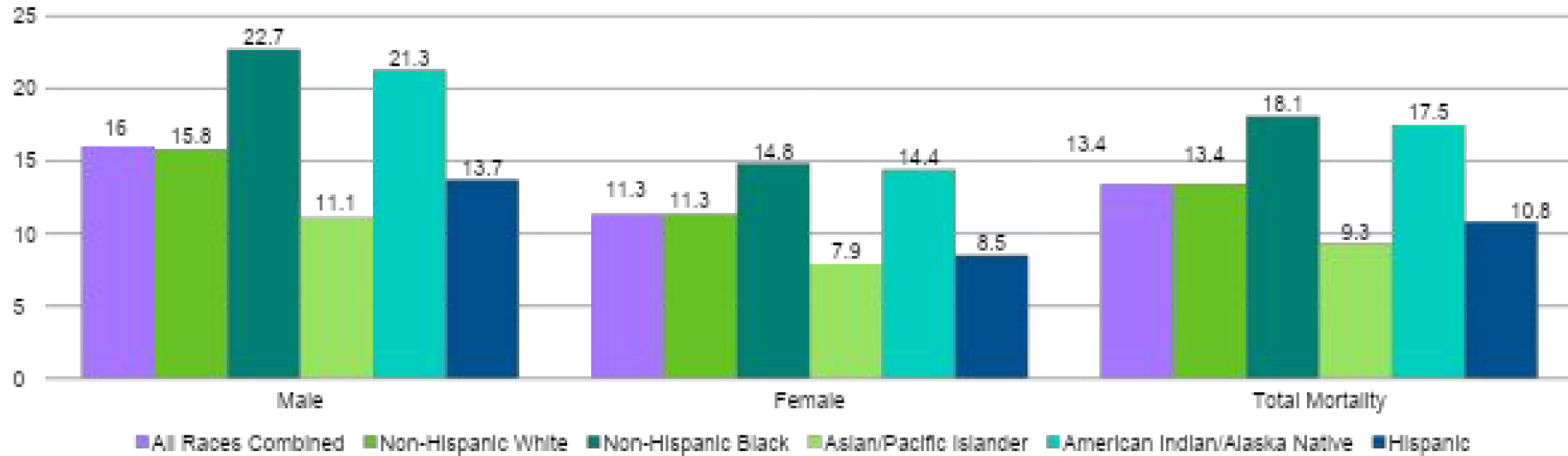
* Note that rates of survival vary by race and ethnicity

Rationale: ACS uses localized, regional, and distant. Need to include the cross-walk to AJCC stages

1. Siegel RL, et al. *CA Cancer J Clin.* 2022;72(1):7-33. doi:10.3322/caac.21708. 2. American Cancer Society. Survival rates for colorectal cancer. Accessed August 3, 2022.

<https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/survival-rates.html>

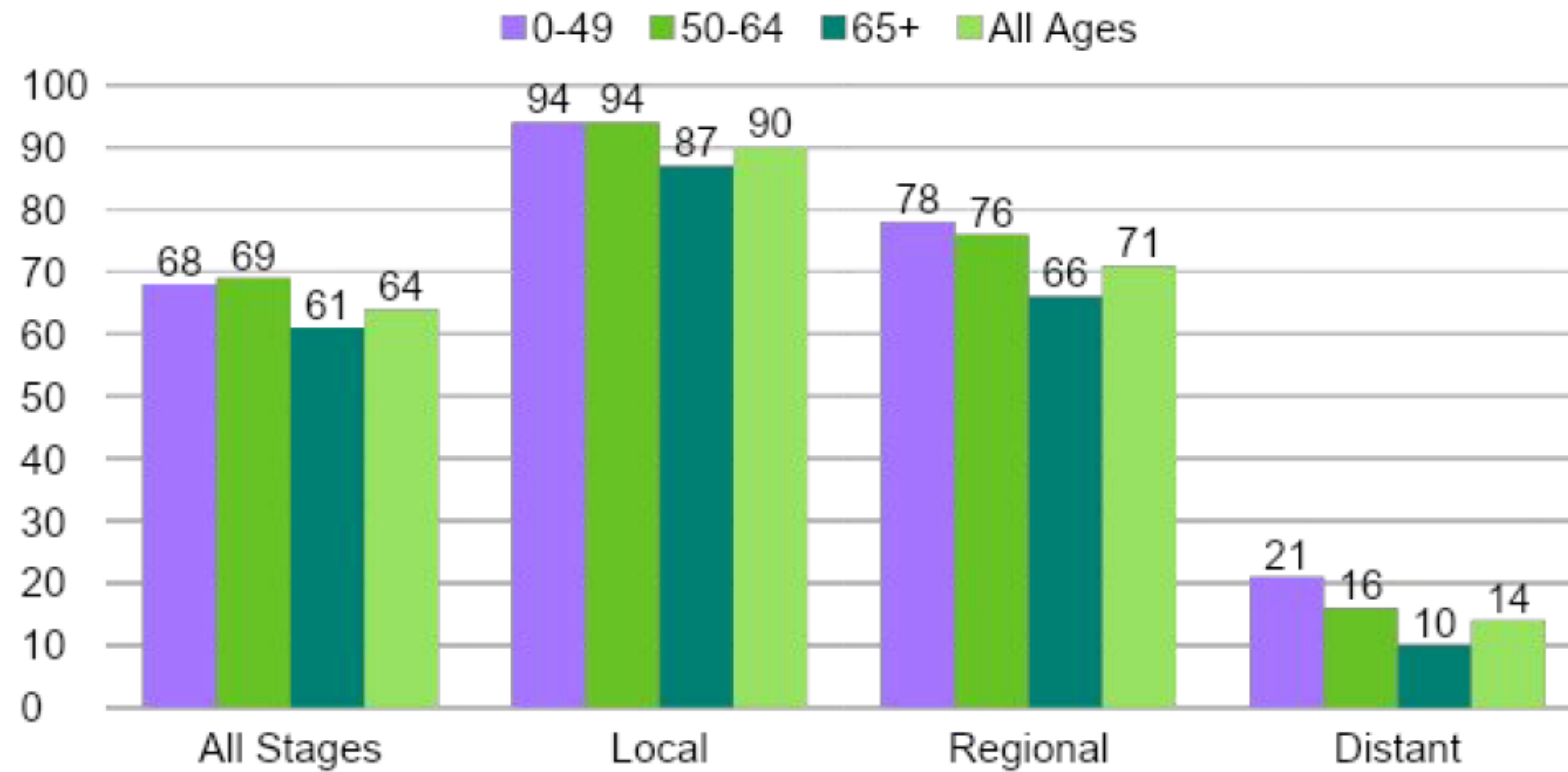
Mortality from CRC by Race, Ethnicity, and Sex in the United States from 2015-2019 (per 100,000 people)



Siegel RL, et al. *CA Cancer J Clin.* 2022;72(1):7-33. doi:10.3322/caac.21708.

CRC 5-year Survival and Stage Distribution by Age

CRC Five-Year Survival (%) by Age



Key Mortality Statistics

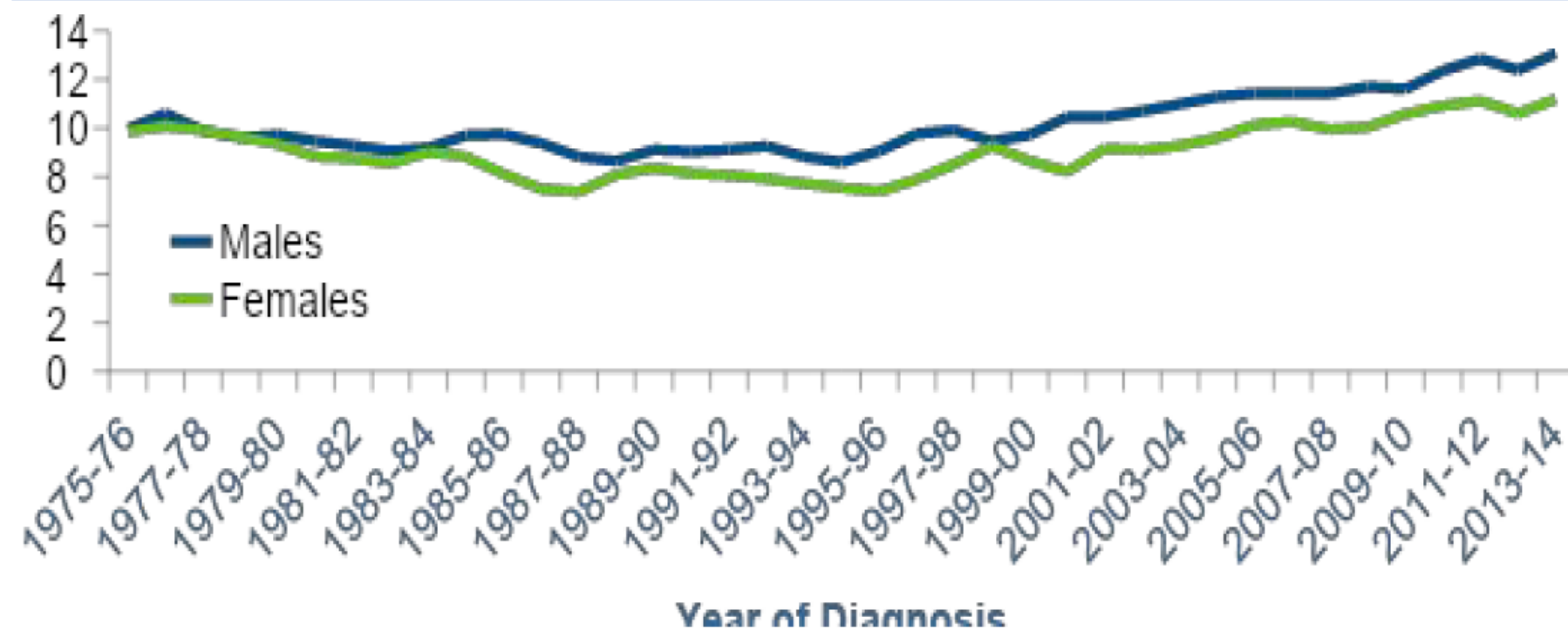
- 0-49 group has 5-yr survival rate of 68% for all stages
- Distant stage CRC has the lowest 5-yr survival rate for all ages

Local: confined to primary site; Regional: spread to regional lymph nodes; Distant: cancer has metastasized
American Cancer Society. Colorectal Cancer Facts & Figures 2020-2022. Atlanta: American Cancer Society; 2020.

Colorectal Cancer in People Aged <50 Years

- ~51% increase in colorectal cancer among those aged <50 years*²
- Colorectal cancer incidence in people aged <50 years increased 2% annually from 2012 to 2016¹

Colorectal Cancer Cases per 100,000 Persons Aged 20-49 Years²



* since 1994

ACS uses localized, regional, and distant. Need to include the cross-walk to AJCC stages

1. Siegel RL, et al. *CA Cancer J Clin.* 2022;72(1):7-33. doi:10.3322/caac.21708. 2. Wolf AMD, et al. *CA Cancer J Clin.* 2018;68(4):250-281.

CRC Overview

Epidemiology

Risk Factors, Signs,
Symptoms

Prevention through
Screening

Incidence

Mortality

Age-Related
Trends

52%

of people aged 50-54 years are **not** up-to-date on colorectal cancer screening¹

Lowering the colorectal cancer screening age to 45 years is likely to impact colorectal cancer incidence and mortality in people aged 50- 54 years¹

The incidence of colorectal cancer is increasing in people aged >54 years versus those aged 50-54 years²

Siegel RL, et al. *CA Cancer J Clin.* 2020;70(3):145-164. 2. Wolf, AMD, et al. *CA Cancer J Clin.* 2019;68:25-281.

COLORECTAL CANCER RISK FACTORS, SIGNS, AND SYMPTOMS



Risk Factors

Signs and Symptoms

Patients are considered high risk if they have one of more of the following:^{1-5†}

A Personal History* of:



- Colorectal cancer, adenomatous polyps, or inflammatory bowel diseases (e.g., Crohn’s disease, ulcerative colitis)
- A confirmed or suspected hereditary colorectal cancer syndrome (e.g., Familial Adenomatous Polyposis or Lynch Syndrome)

A Family History of:



- First-degree relatives (parents, siblings, children) who had colorectal cancer, adenoma or sessile serrated polyp
- Familial adenomatous polyposis
- Hereditary nonpolyposis colorectal cancer syndrome

*ACS guideline excludes patients with radiation to the abdomen/pelvic area to treat prior cancer from the average-risk category.
 †All recommendations are category 2A unless otherwise indicated. The National Comprehensive Cancer Network (NCCN®) makes no representations or warranties of any kind regarding their content, use or application and disclaims any responsibility for their application or use in any way.
CRC: colorectal cancer.

1. American Cancer Society. Colorectal Cancer Facts & Figures 2020-2022. Atlanta: American Cancer Society; 2020. 2. Davidson KW, et al. *JAMA*. 2021;325(19):1965-1977. 3. Wolf AMD, et al. *CA Cancer J Clin*. 2018;68(4):250-281. 4. Rex DK, et al. *Am J Gastroenterol*. 2017;112(7):1016-1030. 5. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Colorectal Cancer Screening V.2.2021. © National Comprehensive Cancer Network®, Inc. 2022. All rights reserved. Accessed February 9, 2022. To view the most recent and complete version of the guideline, go online to NCCN.org.

Additional risk factors for colorectal cancer^{5†}

- Cigarette smoking
- Type 2 Diabetes
- Lack of physical activity
- Excess body weight
- Moderate to high consumption of alcohol
- Moderate to high consumption and/or long-term consumption of red and processed meat
- Low consumption of fiber, calcium, fruits, and vegetables

Note: These factors may be considered when estimating colorectal cancer risk for average-risk individuals, but these alone do not elevate people beyond the average-risk category^{5†}

CRC Overview

Epidemiology

**Risk Factors,
Signs, Symptoms**

Prevention through
Screening

Risk Factors

Signs and Symptoms

Early colorectal cancer often has no symptoms, which is why routine screening is so important.¹

As the tumor grows, it may bleed or block the intestine and cause¹:

- Rectal bleeding
- Blood in stool
- Dark or black stools
- Change in bowel habit or shape of stool
- Cramping or pain in lower abdomen
- Constipation or diarrhea that persists more than a few days
- Decreased appetite
- Unintentional weight loss
- Anemia, fatigue, weakness, or shortness of breath

It is important to catch colorectal cancer early before symptoms develop and when treatment is more effective²

1. American Cancer Society. Colorectal Cancer Facts & Figures 2020-2022. Atlanta: American Cancer Society; 2020.

2. Wolf AMD, et al. *CA Cancer J Clin.* 2018;68(4):250-281.

CRC Overview

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**Prevention through
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Benefits of
Screening

CRC Screening
Adherence

CRC Screening
Guidelines

Shared Decision
Making

Case Studies

COLORECTAL CANCER PREVENTION THROUGH SCREENING



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What is the goal of colorectal cancer screening?¹

- Detect disease in asymptomatic individuals
- Detect and remove precancerous growths
- Detect disease at an earlier stage when treatment is more successful
- Reduce colorectal cancer incidence and mortality
- Increase survival

Five-year Survival Rates (United States, 2019)

- 91%- Stage I/II^{1,2*}
- 15%- Stage IV^{1,2†}

* Note that rates of survival vary by race and ethnicity

† Per American Joint Committee on Cancer's (AJCC) staging system: Localized = stage I, IIa, IIb. Regional = stage IIc and III Distant = stage IV.

1. Siegel RL, Miller KD, Fuchs HE, Jemal A. Cancer statistics, 2022. *CA Cancer J Clin.* 2022;72(1):7-33. 2. American Cancer Society. Survival rates for colorectal cancer. Accessed August 2, 2022.

<https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/survival-rates.html>

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**Prevention through
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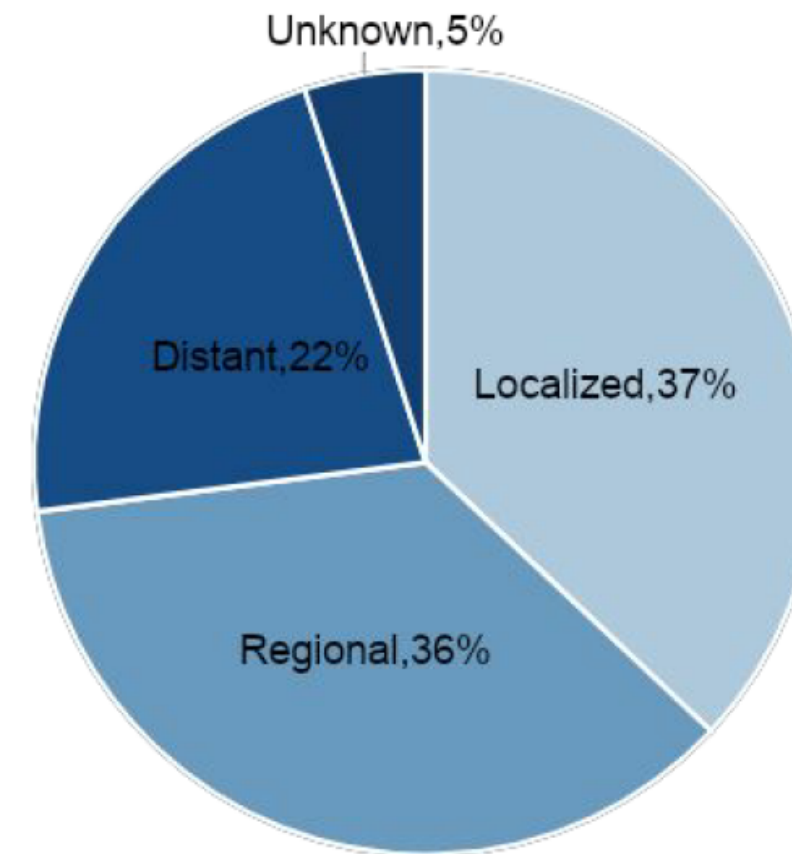
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Colorectal cancer is “the most preventable yet least prevented form of cancer”¹

Yet >50% of colorectal cancer cases are diagnosed at regional and distant stages

Percentage of Cases by Stage²

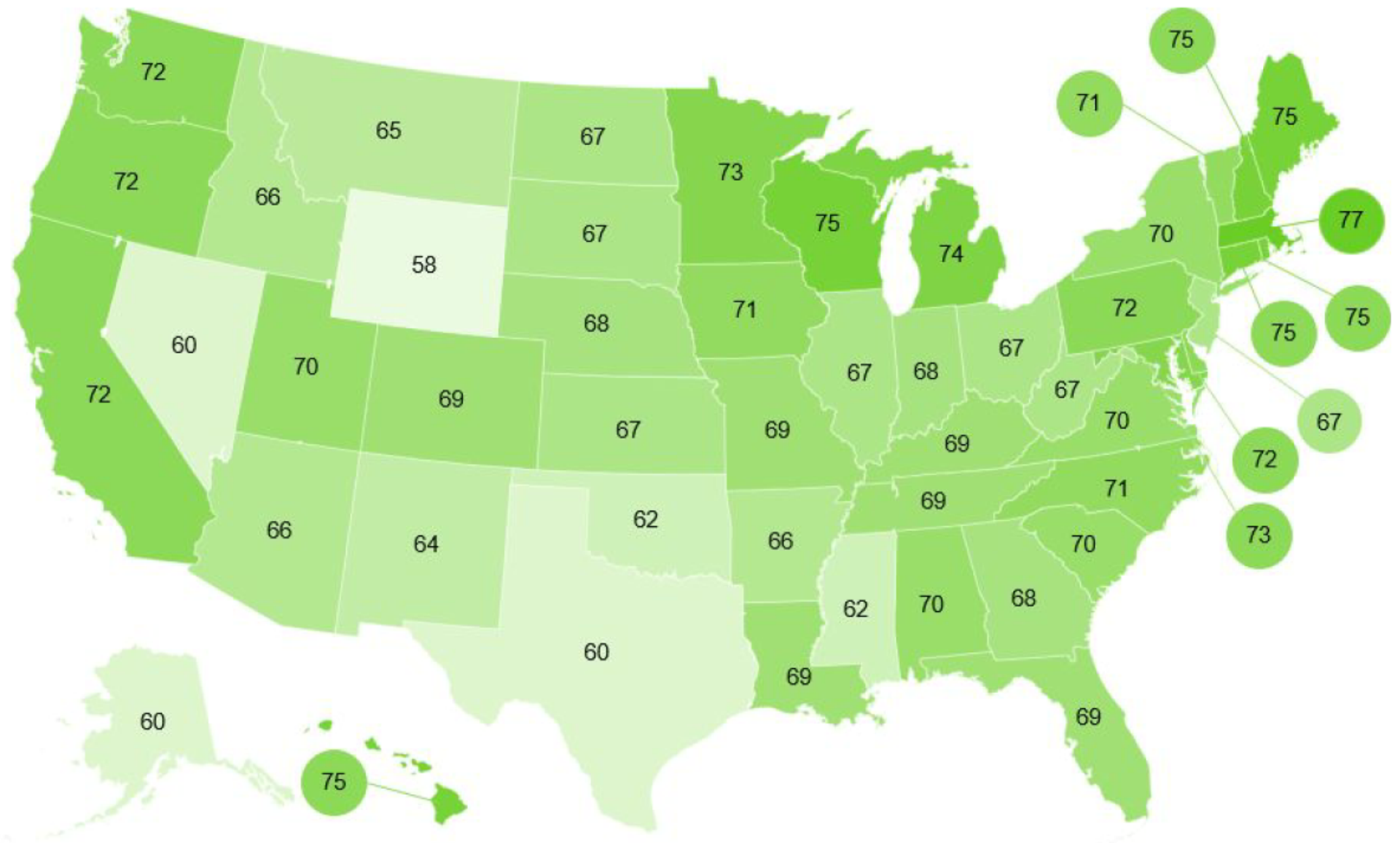


*Based on people with CRC in stage I, stage IIa, or stage IIb between 2011 and 2017.
1. Itzkowitz SH. *J Natl Cancer Inst.* 2009;101(18):1225-1227. 2. NCI. SEER cancer stat facts: colorectal cancer. 2021. Accessed September 20, 2021. <https://seer.cancer.gov/statfacts/html/colorect.html>

CRC SCREENING RATES BY STATE (%), ADULTS AGED ≥50 YEARS, 2018^{1*}

The National Colorectal Cancer Roundtable (NCCRT) set a goal to achieve CRC screening rates of 80% in every community.² Historically, rates of CRC screening adherence in the US have not met this goal in many communities.

Nationally, the current adherence rate is 67%^{1,2}



* Source: Behavioral Risk Factor Surveillance System, 2018. "Screening" considered a stool-based test, a sigmoidoscopy, or a colonoscopy at the recommended interval.
1. ACS. Colorectal cancer facts & figures 2020-2022. Atlanta: American Cancer Society; 2020.
2. NCCRT. Data and progress. Accessed April 13, 2022. <http://nccrt.org/data-progress/>

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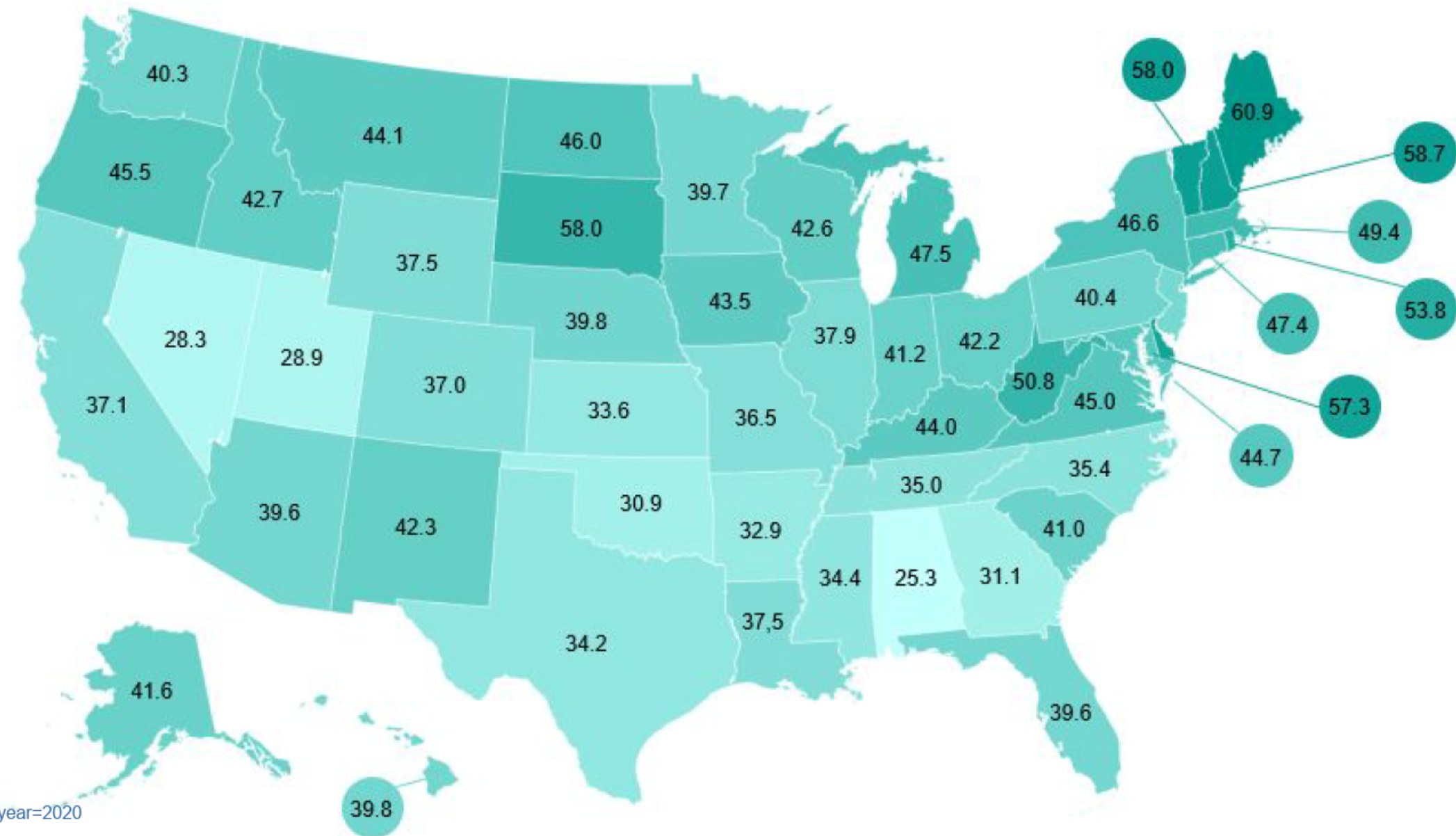
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CRC SCREENING* RATES BY STATE (%), ADULTS AGED 50-74 YEARS, 2020 at FQHCs

The national colorectal cancer screening rate among patients served by FQHCs is **40%**.



* "Appropriate screening" for colorectal cancer
HRSA. 2020 Health Center Data. Accessed February 22, 2022.
<https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=Full&year=2020>

Benefits of Screening		CRC Screening Adherence	CRC Screening Guidelines	Shared Decision Making	Case Studies	
Recommendations	US Preventive Services Task Force (USPSTF) 2021 ¹	American Cancer Society (ACS) 2018 ²	NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines [®]) 2022 ^{3*}	American College of Gastroenterology (ACG) 2021 ⁴	Multi-Society Task Force (MSTF) 2021 ^{5†}	
Choice of Test	Clinicians and patients may consider a variety of factors in deciding which test may be best for each person	High-sensitivity stool-based test or a structural (visual) exam, depending on patient preference and test availability	Discussion of potential harms/risks and benefits and consideration of all recommended CRC screening options	Colonoscopy and FIT as primary screening modalities, with flex sig, mt-sDNA, CTC, or colon capsule for those unable or unwilling to undergo colonoscopy or FIT	Screening with colonoscopy every 10 years or annual FIT as first-tier options	
Direct Visual Examination	Colonoscopy	Every 10 years	Every 10 years	Every 10 years	Every 10 years	Every 10 years (Tier 1)
	CT colonography	Every 5 years	Every 5 years	Every 5 years	Every 5 years	Every 5 years (Tier 2)
	FS	Every 5 years	Every 5 years	Every 5-10 years	Every 5-10 years	Every 5 or 10 years (Tier 2)
	FS with FIT	FS every 10 years with annual FIT	--	--	--	--
	Capsule colonoscopy	--	--	--	Every 5 years	Every 5 years (Tier 3)
Stool-based Tests	hs-gFOBT	Annual	Annual	Annual	--	--
	FIT	Annual	Annual	Annual	Annual	Annual (Tier 1)
	mt-sDNA[†]	Every 1 to 3 years	Every 3 years	Every 3 years	Every 3 years	Every 3 years (Tier 2)
All Positive Results on Non-colonoscopy Screening Tests Should Be Followed up with a Timely Colonoscopy						

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[†]Nomenclature based on different guidelines: mt-sDNA, sDNA-FIT or FIT-FECAL DNA.

[‡]See Rex DK, et al. *Am J Gastroenterol.* 2017;112(7):1016-1030 for additional MSTF recommendations. The United States Multi-Society Task Force on Colorectal Cancer includes the American College of Gastroenterology (ACG), the American Gastroenterological Association (AGA), and the American Society for Gastrointestinal Endoscopy (ASGE).

CRC: colorectal cancer; **CTC:** computed tomography colonography; **FIT:** fecal immunochemical test; **FS:** flexible sigmoidoscopy; **hs-gFOBT:** high sensitivity guaiac-based fecal occult blood test; **mt-sDNA:** multi-target stool DNA test.

EXACT SCIENCES 1. Davidson KW, et al. *JAMA.* 2021;325(19):1965-1977. 2. Wolf AMD, et al. *CA Cancer J Clin.* 2018;68(4):250-281. 3. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines[®]) for Colorectal Cancer Screening V.1.2022. © National Comprehensive Cancer Network, Inc. 2022. All rights reserved. Accessed March 4, 2022. To view the most recent and complete version of the guideline, go online to NCCN.org. 4. Shaikat A, et al. *Am J Gastroenterol.* 2021;116:458-479. 5. Patel SG, et al. *Gastroenterol.* 2022;162(1):285-299. Do Not Distribute. Not for Promotional Use.

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Most major professional organizations recommended screening for colorectal cancer in average-risk adults starting at age 45

Guideline	Recommendation to Begin Screening at Age	Considerations
US Preventive Services Task Force (USPSTF) 2021 ¹	≥45 yo average-risk individuals	• Screen adults aged 45-49 years for colorectal cancer. Grade B*
NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines [®]) 2022 ^{2†}	≥45 yo [†] average-risk individuals	• The choice of a particular screening modality should include a conversation with the patient concerning their preference and availability
American Cancer Society (ACS) 2018 ³	≥45 yo average-risk individuals	• <i>Qualified</i> ** recommendation based on disease burden, modeling data and expectation that screening performs similarly in 45-49 yo group as in 50+ group
Multi-Society Task Force (MSTF) 2021 ^{4§}	≥45 yo average-risk individuals	• Weak recommendation; low-quality evidence • Average-risk individuals not screened before age 50 should be offered CRC screening beginning at age 50 (strong recommendation, high-quality evidence)
American College of Gastroenterology (ACG) 2021 ⁵	Average-risk individuals 45-49 yo	• Conditional recommendation strength based on very low quality of evidence

*The USPSTF concludes with moderate certainty that screening for CRC in adults aged 45 to 49 years has moderate net benefit (Grade B).

***Qualified* recommendation: clear evidence of benefit (or harm) but less certainty either about the balance of benefits and harms or about patients' values and preferences, which could lead to different individual decisions.

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‡The panel for the NCCN Guidelines for Colorectal Cancer Screening agrees that the data are stronger to support beginning screening at 50 years but acknowledges that lower-level evidence supports a benefit for screening earlier. When initiating screening for all eligible individuals, a discussion of potential harms/risks and benefits, and the consideration of all recommended CRC screening options, is recommended.

§ The United States Multi-Society Task Force on Colorectal Cancer includes the American College of Gastroenterology (ACG), the American Gastroenterological Association (AGA), and the American Society for Gastrointestinal Endoscopy (ASGE).

YO: year old.

EXACT SCIENCES 1. Davidson KW, et al. *JAMA*. 2021;325(19):1965-1977. 2. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines[®]) for Colorectal Cancer Screening V.1.2022. © National Comprehensive Cancer Network, Inc. 2022. All rights reserved. Accessed March 4, 2022. To view the most recent and complete version of the guideline, go online to NCCN.org. 3. Wolf AMD, et al. *CA Cancer J Clin*. 2018;68(4):250-281. 4. Patel SG, et al. *Gastroenterol*. 2022;162(1):285-299. 5. Shaukat AK, et al. *Am J Gastroenterol*. 2021;116(3):458-479.

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Recommendations	US Preventive Services Task Force (USPSTF) 2021 ¹	American Cancer Society (ACS) 2018 ²	NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines [®]) 2022 ^{3*}	American College of Gastroenterology (ACG) 2021 ⁴	Multi-Society Task Force (MSTF) 2021 ^{5§}
Age to Begin Screening	45 years (Grade B ^{**})	45 years (qualified [†])	45 years [‡] (category 2A)	45 years (conditional recommendation [suggested]; very low-quality evidence)	45 years (weak recommendation, low-quality evidence)
Continue Screening Until Age	75 years (Grade A ^{**})	75 years (qualified [†])	75 years (category 2A)	75 years (strong recommendation; moderate-quality evidence)	75 years, up to date and prior negative screening, or life expectancy is <10 years (weak recommendation, low-quality evidence)
Screening After Age 75	Selectively screen adults aged 76-85, considering patient's overall health, prior screening and preferences (Grade C ^{**})	Individualized decision for screening at ages 76-85 years (qualified [†]) Discourage continuing screening of adults >85 years (qualified [†])	Individualized decision that should include a discussion of the risks and benefits based on comorbidity status and estimated life expectancy (category 2A)	Individualized decision for screening (conditional recommendation [suggested]; very low-quality evidence)	Consideration for screening up to age 85 in previously unscreened (recommendation based on patient age and comorbidities) (weak recommendation, low-quality evidence)

^{**}The USPSTF concludes with moderate certainty that screening for CRC in adults aged 45 to 49 years has moderate net benefit (Grade B). The USPSTF concludes with high certainty that screening adults aged 50 to 75 years has substantial net benefit (Grade A). The USPSTF concludes with moderate certainty that there is a small net benefit of screening for colorectal cancer in adults aged 76 to 85 y who have been previously screened (Grade C).

[†]The "qualified" designation indicates that there is clear evidence of benefit (or harm) but some uncertainty on the balance of benefits/harms or patient values/preferences, which can influence individual decisions.

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[‡]The panel for the NCCN Guidelines for Colorectal Cancer Screening agrees that the data are stronger to support beginning screening at 50 years but acknowledges that lower-level evidence supports a benefit for screening earlier. When initiating screening for all eligible individuals, a discussion of potential harms/risks and benefits, and the consideration of all recommended CRC screening options, is recommended.

[§]The United States Multi-Society Task Force on Colorectal Cancer includes the American College of Gastroenterology (ACG), the American Gastroenterological Association (AGA), and the American Society for Gastrointestinal Endoscopy (ASGE).

CRC: colorectal cancer.
EXACT SCIENCES

1. Davidson KW, et al. *JAMA*. 2021;325(19):1965-1977. 2. Wolf AMD, et al. *CA Cancer J Clin*. 2018;68(4):250-281. 3. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines[®]) for Colorectal Cancer Screening V.1.2022. © National Comprehensive Cancer Network, Inc. 2022. All rights reserved. Accessed March 4, 2022. To view the most recent and complete version of the guideline, go online to NCCN.org. 4. Shaikat A, et al. *Am J Gastroenterol*. 2021;116:458-479 5. Patel SG, et al. *Gastroenterol*. 2022;162(1):285-299.

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In Shared Decision Making, Health Care Providers Offer Options and Describe Their Risks and Benefits, and Patients Express Their Preferences and Values¹

National Guidelines Recommend Shared Decision Making to Improve Screening Adherence

US Preventive Services
Task Force (USPSTF)
2021²

“Several recommended screening tests are available. Clinicians and patients may consider a variety of factors in deciding which test may be best for each person”
“Discussion with patients may help better identify screening tests that are more likely to be completed by a given individual”

American
Cancer Society
(ACS) 2018³

“The importance of offering a choice between structural or stool-based testing is included in this guideline in recognition of the role of patient values and preferences and as a practical implementation strategy to improve adherence”

NCCN Clinical Practice
Guidelines in Oncology
(NCCN Guidelines[®]) 2022^{4*}

“Because there are multiple options for screening, the choice of a particular screening modality should include a conversation with the patient concerning their preference and availability”

American College of
Gastroenterology
(ACG) 2021⁵

“The ‘ideal’ screening test should be noninvasive, have high sensitivity and specificity, be safe, readily available, convenient, and inexpensive. For CRC screening, there are multiple approved tests and strategies, each with its strengths and weaknesses. In some instances, the ‘best’ screening test can be considered the one that is acceptable to the patient and gets completed.”

All recommendations are category 2A unless otherwise indicated. The National Comprehensive Cancer Network (NCCN[®]) makes no representations or warranties of any kind regarding their content, use or application and disclaims any responsibility for their application or use in any way.
1. Moyer VA, et al. *N Engl J Med*. 2012;366(9):780-781. 2. Davidson KW, et al. *JAMA*. 2021;325(19):1965-1977. 3. Wolf AMD, et al. *CA Cancer J Clin*. 2018;68(4):250-281. 4. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines[®]) for Colorectal Cancer Screening V.1.2022. © National Comprehensive Cancer Network, Inc. 2022. All rights reserved. Accessed March 4, 2022. To view the most recent and complete version of the guideline, go online to NCCN.org. 5. Shaikat et al. 2021 *Am J Gastroenterol*. 2021;116:458-479.

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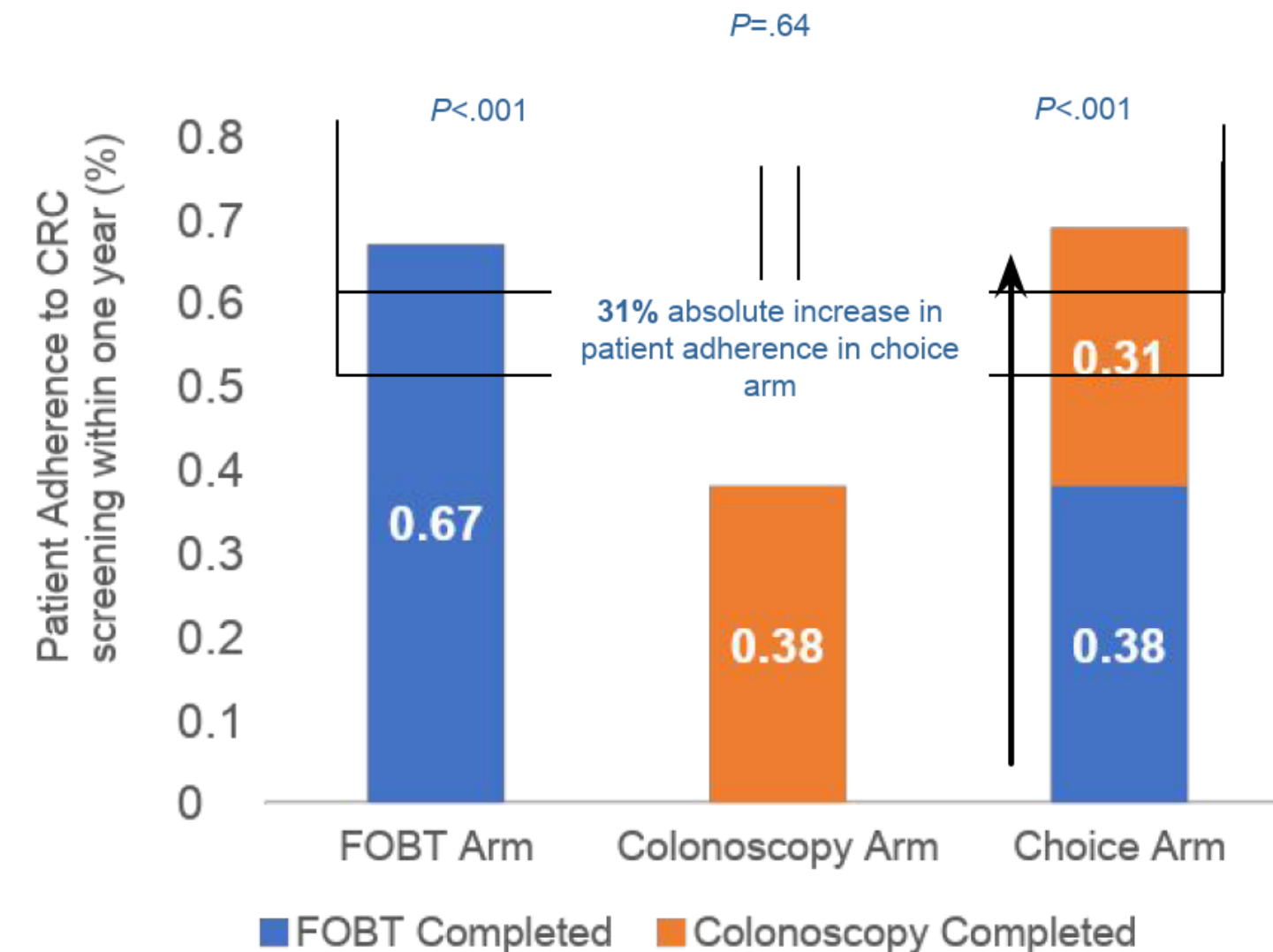
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Offering choice of screening method may improve CRC screening rates

- In a randomized controlled trial of adults aged 50–79 years at average risk of CRC (N=997), health care providers offered a choice of CRC screening recommendations (FOBT, colonoscopy, or choice of either)
- Patient adherence to CRC screening increased by 31% when patients were given a choice of test compared with only offering colonoscopy
- African American, Asian, and Latino patients preferred non-invasive fecal testing over colonoscopy.



References: Inadomi JM, et al. Adherence to colorectal cancer screening: a randomized clinical trial of competing strategies. *Arch Intern Med.* 2012;172(7):575-582.

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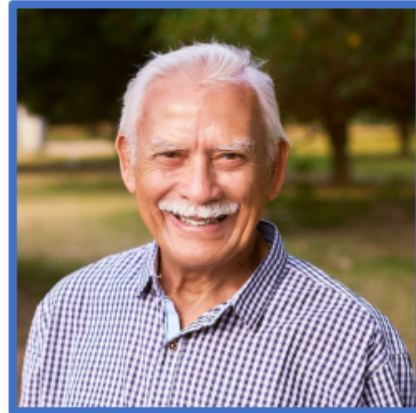
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Miguel

- 75-year-old Latino male
- Recently immigrated from El Salvador; speaks limited English
- Presents to clinic for management of diabetes
- Has a family history of colorectal cancer; was screened for colorectal cancer 12 years ago



Katie

- 45-year-old White female with three children aged 9, 13, and 22
- Born in the United States
- Presents to clinic for annual physical exam
- Hasn't previously been recommended for colorectal cancer screening



Jim

- 55-year-old Black male with two sons aged 33 and 34
- Born in the United States
- Presents to clinic for chronic cough due to post-COVID syndrome
- Hasn't previously been recommended for colorectal cancer screening

*Not Actual Patients

Image credit: Shutterstock

Case studies presented reflect the real-life case(s) of a patient and/or are representative of real-life case(s). These case studies are for educational purposes only and should not be interpreted as an endorsement by Exact Sciences of any individual, service, product, or therapy. Individual results will vary. Case studies sometimes relate to interpretive diagnostic opinions, which are made by the treating physician, and do not necessarily represent the "standard of care".



Additional Information about Miguel and Summary of Risk Factors

- Mother was diagnosed with colorectal cancer at age 60
- Has Type 2 diabetes
- Does not smoke, but drinks alcohol occasionally
- Aged 75 years

Miguel is not considered average risk for colorectal cancer and should be screened via colonoscopy

What is Miguel’s risk of developing colorectal cancer?

Heredity and Medical History ¹	Relative Risk*
Family history of CRC	
1 or more first-degree relatives (mother, father, brother, sister)	2.2
1 or more first-degree relatives diagnosed before age 50	3.6
2 or more first-degree relatives	4.0
1 or more second-degree relatives	1.7
Type 2 diabetes	
Male	1.4
Female	1.2

*Relative risk compares the risk of disease among people with a particular “exposure” to the risk among people without that exposure. Relative risk for dietary factors compares the highest with the lowest consumption. If the relative risk is more than 1.0, then risk is higher among exposed than unexposed persons. Relative risks less than 1.0 indicate a protective effect.

CRC: colorectal cancer.

Reference: 1. American Cancer Society. Colorectal cancer facts & figures 2020-2022. Atlanta: American Cancer Society; 2020.

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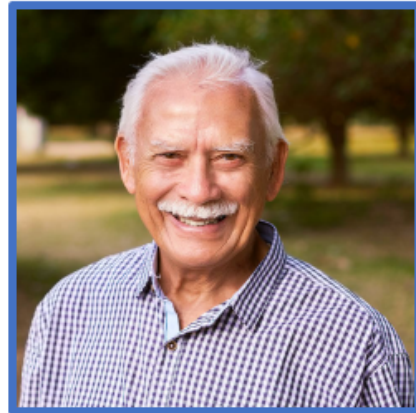
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Miguel's Self-Reported Barriers to Screening

- Hasn't been screened for colorectal cancer in 12 years because he hasn't had symptoms
- Knows he should be screened but hasn't had time due to his recent move
- Feels medical appointments are reserved for illness rather than preventive care
- Fears surprise medical bills

These barriers are not unique to patients like Miguel.

Motivating Miguel and Other Hispanic and Latino Men to be Screened

- Note that delaying screening can be life threatening^{1*}
- Provide mortality statistics specific to Hispanic community^{1*}
- Indicate he has a responsibility to their family as the head of household^{1*}

*Market research conducted with focus groups of key informants and unscreened White, Black, and Hispanic participants aged 45-65 years from FL, GA, and NY. Participant responses may have been influenced by the COVID-19 pandemic.
Reference: 1. Zebra Strategies. Black/Hispanic CRC Research. Attitudes & Awareness Among Blacks & Hispanics About Colorectal Cancer. 2020. (Market Research).

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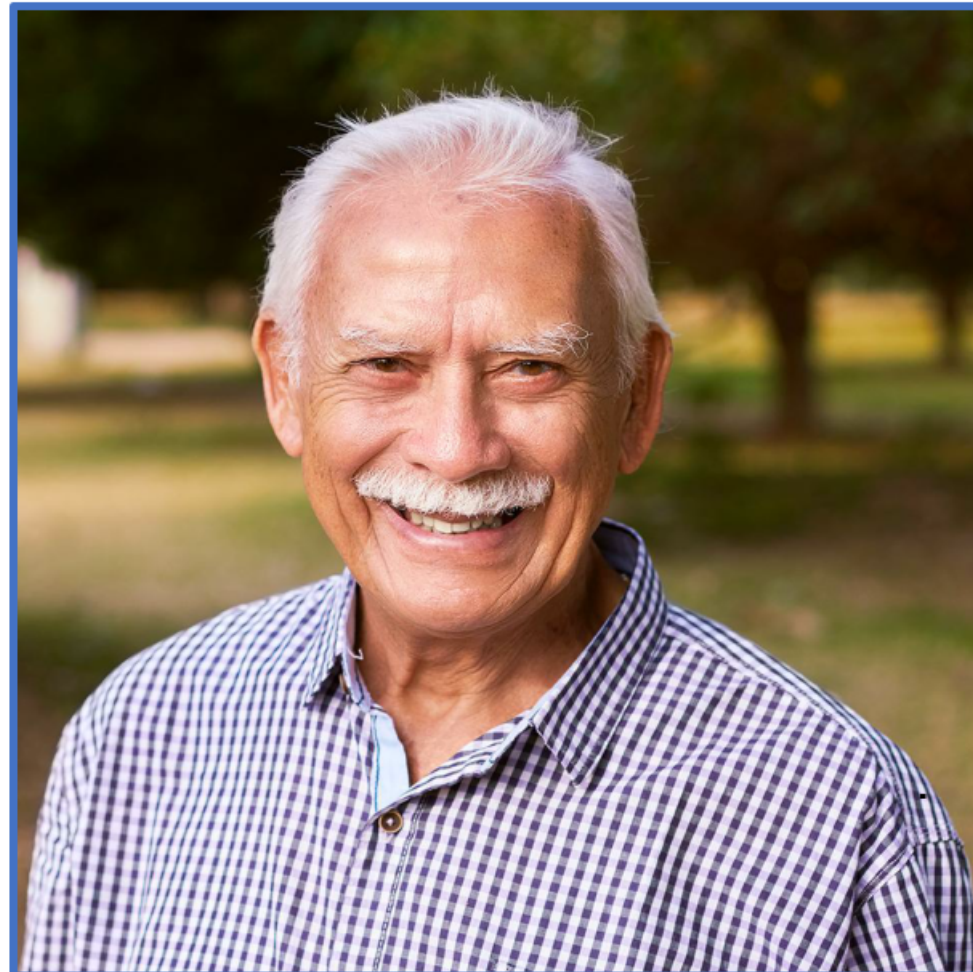
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After a discussion with his provider, Miguel chose to have a colonoscopy because he is at high risk for colorectal cancer.

He was motivated because he wants to spend more years with his son and grandchildren.

† This message increased intention to participate in colorectal cancer screening within six months
Reference: 1. NCCRT. 2019 Colorectal Cancer Screening Messaging Guidebook: Recommended Messages To Reach the Unscreened. 2019.



Additional Information about Katie and Summary of Risk Factors

- Has obesity (BMI of 38 kg/m²)
- History of smoking (1 pack/day for 20 years)
- Sedentary lifestyle
- High consumption of fast food
- Aged 45 years¹⁻²

Katie's age puts her at the recommended age to begin screening.^{1,2} Although she has modifiable risk factors for disease, she is considered average risk.

What is Katie's risk of developing colorectal cancer?

Medical History	Increased Risk
Overweight and Obesity	
Obesity ¹	
• Per unit increase in BMI ¹	• +1.5-2.8-fold
• Risk of adenoma: per 5-unit increase in BMI ²	• +3%
• Abdominal obesity associated with greater risk than truncal obesity or BMI ¹	• +19%
Diet³	
• There is an association between lower colorectal cancer risk and higher intakes of dietary fiber, dietary calcium and yogurt and lower intakes of alcohol and red meat	
• More research is needed on specific foods for which evidence remain suggestive, including other dairy products, whole grains, processed meat, and specific dietary patterns	

BMI: body mass index

References: 1. Davidson KW, et al. *JAMA*. 2021;325(19):1965-1977. 2. Wolf AMD, et al. *CA Cancer J Clin*. 2018;68(4):250-281. 3. Rex DK, et al. *Am J Gastroenterol*. 2009;104:739-750. 4. Ben Q, et al. *Gastroenterol*. 2012;142(4):762-772. 5. Veetil SK, et al. *JAMA Netw Open*. 2021;(4(2):e2037341.

EXACT SCIENCES



Katie's Self-Reported Barriers to Screening

- Hasn't been recommended for screening
- Doesn't think she's old enough to be screened
- Doesn't have symptoms or family history of colorectal cancer

Motivating People Like Katie to be Screened¹

- Education on importance of screening and the risk of being unscreened
- Note that colorectal cancer can be prevented if caught early
- Discuss available screening options that will fit in with her lifestyle
- Discuss the costs related to screening options

These barriers are not unique to patients like Katie.

Reference: 1. NCCRT. 2019 Colorectal Cancer Screening Messaging Guidebook: Recommended Messages To Reach the Unscreened. 2019.

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In message testing conducted by the NCCRT, the following message increased intent to be screened by 11.8%[†]

“A colonoscopy isn’t the only option for colorectal cancer screening. There are simple, affordable options, including tests that can be done at home. Talk to your doctor about which option is right for you. Ask which tests are covered by your health insurance.”

After a discussion with her provider, Katie chose to be screened via stool-based testing because she won’t have to take time off from work.

[†] This message increased intention to participate in colorectal cancer screening within six months
Reference: 1. NCCRT. 2019 Colorectal Cancer Screening Messaging Guidebook: Recommended Messages To Reach the Unscreened. 2019.



Additional Information about Jim and Summary of Risk Factors

- Has obesity (BMI of 30 kg/m²)
- Current smoker (2 packs/day)
- Sedentary lifestyle
- Black race
- Aged 55 years

Although he has modifiable risk factors for disease, Jim is considered at average risk of developing disease and should be screened.

What is Jim’s risk of developing colorectal cancer?

Heredity and Medical History ¹	Increased Risk
<p>Race¹</p> <ul style="list-style-type: none"> • Compared to non-Hispanic whites, incidence rates of CRC are 24% higher in non-Hispanic Black men and 19% higher in non-Hispanic Black women • CRC death rates are 47% higher in non-Hispanic Black men and 34% in non-Hispanic Black women compared to in non-Hispanic white men and women 	
<p>Smoking²</p> <ul style="list-style-type: none"> • 20 pack-years and increase risk of advanced adenoma • Patients with colorectal cancer with a history of smoking <ul style="list-style-type: none"> • Increased risk may continue for as long as 20 years after smoking cessation 	<ul style="list-style-type: none"> • +2-3-fold • 20%

BMI: body mass index; CRC: colorectal cancer.

1. ACS. Cancer facts & figures for African Americans 2019-2021. Atlanta: American Cancer Society; 2019. 2. Rex DK, et al. Am J Gastroenterol. 2009;104:739-750.



Jim’s Self-Reported Barriers to Screening

- Physician hasn’t recommended screening
- Doesn’t want to complete the bowel prep process
- Doesn’t feel like colorectal cancer could happen to him
- No family history of colorectal cancer
- Unsure if screening is covered by his insurance

These barriers are not unique to patients like Jim.

Motivating Jim and Other Black Individuals to be Screened

- Discuss the prevalence of colorectal cancer among Black and African American men^{1*}
- Note that symptoms don’t often appear until later stages of disease^{1*}
- Indicate that screening can save lives^{1*}
- If the patient has a family history of colorectal cancer, discuss the increased risk of developing colorectal cancer^{1*}

*Market research conducted with focus groups of key informants and unscreened White, Black, and Hispanic participants aged 45-65 years from FL, GA, and NY. Participant responses may have been influenced by the COVID-19 pandemic. References: 1. Zebra Strategies. Black/Hispanic CRC Research. Attitudes & Awareness Among Blacks & Hispanics About Colorectal Cancer. 2020. (Market Research).

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Among Black individuals who feel impervious or fearful and have cost concerns, the following message increased intent to be screened by up to 15.7%^{†2}

“Did you know that colorectal cancer is the third-leading cause of cancer death in both Black men and women in the United States? Colorectal cancer can be caught early or even prevented through regular screening. Most people should begin screening at age 45. ^{1†}

After a discussion with his provider, Jim chose to be screened via a stool-based test because he wanted to catch colorectal cancer early.

[†] In message testing conducted by the NCCRT, the following message increased intent to be screened for colorectal cancer.
Reference: 1. NCCRT. 2022 Messaging Guidebook For Black & African American People: Messages To Motivate For Colorectal Cancer Screening. 2022.

CRC Overview



CRC is 3rd most common cancer and 2nd leading cause of cancer mortality¹

Epidemiology



Earlier detection improves survival¹

~70%

~70% of CRC develops from adenomas²

Risk Factors, Signs, Symptoms



CRC incidence is increasing in younger populations, and is expected to continue to increase^{3,4}

45+

Professional organizations recommend screening for CRC in average-risk adults starting at age 45⁵⁻⁸

Prevention through Screening



Offering patients a choice of screening tests can improve CRC screening adherence.⁹

CRC: colorectal cancer, **ACS:** American Cancer Society.

1. Siegel RL, et al. *CA Cancer J Clin.* 2022; 72(1):7-33. <https://doi.org/10.3322/caac.2172>. Rex DK, et al. *Am J Gastroenterol.* 2017;112(7):1016-1030. 3. Siegel et al. *CA Cancer J Clin.* 2020;70(3):145-164. 4. Bailey CE, et al. *JAMA Surg.* 2015;150(1):17. 5. Davidson KW, et al. *JAMA.* 2021;325(19):1965-1977. 6. National Comprehensive Cancer Network. Clinical practice guidelines in oncology - colorectal cancer screening. Version 2.2021. Updated April 13, 2021. Accessed October 1, 2021. https://www.nccn.org/professionals/physician_gls/pdf/colorectal_screening.pdf 7. Wolf AMD, et al. *CA Cancer J Clin.* 2018;68(4):250-281. 8. Shaikat A, et al. *Am J Gastroenterol.* 2021;116:458-479. 9. Inadomi JM, et al. Adherence to colorectal cancer screening: a randomized clinical trial of competing strategies. *Arch Intern Med.* 2012;172(7):575-582.

EXACT SCIENCES

THANK YOU WHAT QUESTIONS DO YOU HAVE?



CRC Overview

Epidemiology

Risk Factors, Signs,
Symptoms

Prevention through
Screening

Visual Screening
Tests

Stool-Based Screening
Tests

APPENDIX



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SCIENCES

CRC Overview

Epidemiology

Risk Factors, Signs, Symptoms

Prevention through Screening

Visual Screening Tests

Stool-Based Screening Tests

Visual Screening Test	Benefits	Limitations	Test Time Interval
Colonoscopy	<ul style="list-style-type: none"> Examines entire colon Can biopsy and remove polyps Can diagnose other diseases Required for abnormal results from all other tests 	<ul style="list-style-type: none"> Full bowel cleansing Can be expensive Sedation usually needed, necessitating a chaperone to return home Patient may miss a day of work Highest risk of bowel tears or infections compared with other tests 	10 years [†]
Computed tomographic colonography (CTC)	<ul style="list-style-type: none"> Examines entire colon Fairly quick Few complications No sedation needed Noninvasive 	<ul style="list-style-type: none"> Full bowel cleansing Cannot remove polyps or perform biopsies Exposure to low-dose radiation Colonoscopy necessary if positive Not covered by all insurance plans 	5 years
Flexible Sigmoidoscopy (FS)	<ul style="list-style-type: none"> Fairly quick Few complications Minimal bowel preparation Does not require sedation or a specialist 	<ul style="list-style-type: none"> Partial bowel cleansing Views only one-third of colon Cannot remove large polyps Small risk of infection or bowel tear Slightly more effective when combined with annual fecal occult blood testing Colonoscopy necessary if positive Limited availability 	5 years

*Complexity involves patient preparation, inconvenience, facilities and equipment needed, and patient discomfort.

[†]For average-risk individuals only and does not apply to those who have a history of adenoma.

CTC: colorectal cancer.

American Cancer Society. Colorectal Cancer Facts & Figures 2020-2022. Atlanta: American Cancer Society; 2020.

Visual Screening Tests

Stool-Based Screening Tests

Stool-Based Screening Test	Benefits	Limitations	Test Time Interval
Fecal immunochemical test (FIT)	<ul style="list-style-type: none"> No bowel cleansing or sedation Performed at home Low cost Noninvasive 	<ul style="list-style-type: none"> Requires multiple stool samples Will miss most polyps May produce false-positive test results Slightly more effective when combined with a flexible sigmoidoscopy every five years Colonoscopy necessary if positive 	Annual
High-sensitivity guaiac-based fecal occult blood test (gFOBT)	<ul style="list-style-type: none"> No bowel cleansing or sedation Performed at home Low cost Noninvasive 	<ul style="list-style-type: none"> Requires multiple stool samples Will miss most polyps May produce false-positive test results Pre-test dietary limitations Slightly more effective when combined with a flexible sigmoidoscopy every five years Colonoscopy necessary if positive 	Annual
Multitarget stool DNA test (Cologuard®)	<ul style="list-style-type: none"> No bowel cleansing or sedation Performed at home Requires only a single stool sample Noninvasive 	<ul style="list-style-type: none"> Will miss most polyps More false-positive results than other tests Higher cost than gFOBT and FIT Colonoscopy necessary if positive 	3 years

*Complexity involves patient preparation, inconvenience, facilities and equipment needed, and patient discomfort.

CRC: colorectal cancer.

American Cancer Society. Colorectal Cancer Facts & Figures 2020-2022. Atlanta: American Cancer Society; 2020.

ACT SCIENCES



Comprehensive Cancer
Alliance for Idaho



Action Through Advocacy

ERIN RIELY

American Cancer Society - Cancer Action Network



February 23, 2023

CCAI Annual Meeting





Erin Riley

Idaho Grassroots Manager

“My first mammogram was in 2020. I was underinsured and placed into the high risk category. It’s a really scary place to be when you have to decide whether to pay for continued screenings or pay for rent and groceries. I now work for an organization that believes no one should be disadvantaged in their fight against cancer. I’m grateful to work with passionate volunteers from across that state who work with Idaho lawmakers to make fighting cancer a top priority.”



Randy Johnson
Government Relations Director

"I'm honored to do my part to help advance legislation and policies that will save lives from this horrible disease. After losing my father to liver cancer, I do not want anyone to go through that. I look forward to working with elected officials, volunteers, community partners and leaders, and organizations across our state to help reduce suffering and death from cancer in Idaho."



Action Through Advocacy



Vision: End cancer as we know it, for everyone.

Mission: Improve the lives of people with cancer and their families through advocacy, research, and patient support, to ensure everyone has an opportunity to prevent, detect, treat, and survive cancer.

Patient Support

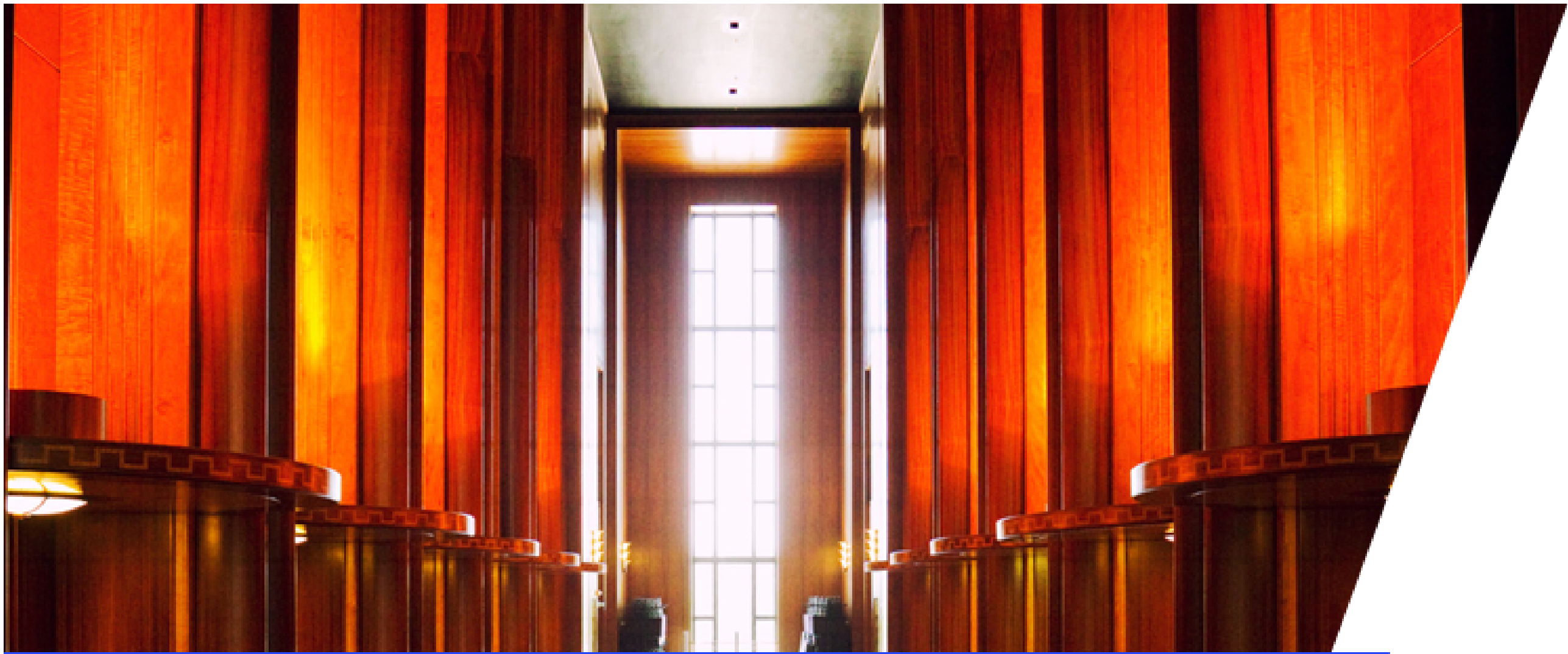
A white line-art icon on a grey background showing a doctor with a stethoscope and a patient.

Action through advocacy

The logo for the American Cancer Society Cancer Action Network, featuring a stylized building icon and the text "American Cancer Society Cancer Action Network".

Advancing discovery

A white line-art icon of a microscope on a dark blue background.



Where you live should not determine if you live.



What is ACS CAN?

The American Cancer Society Cancer Action Network (ACS CAN) is making cancer a top priority for public officials and candidates at the federal, state and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change as well as legislative and regulatory solutions that will reduce the cancer burden.





Volunteer Training & Cancer Action Day

March 12 & 13, 2023

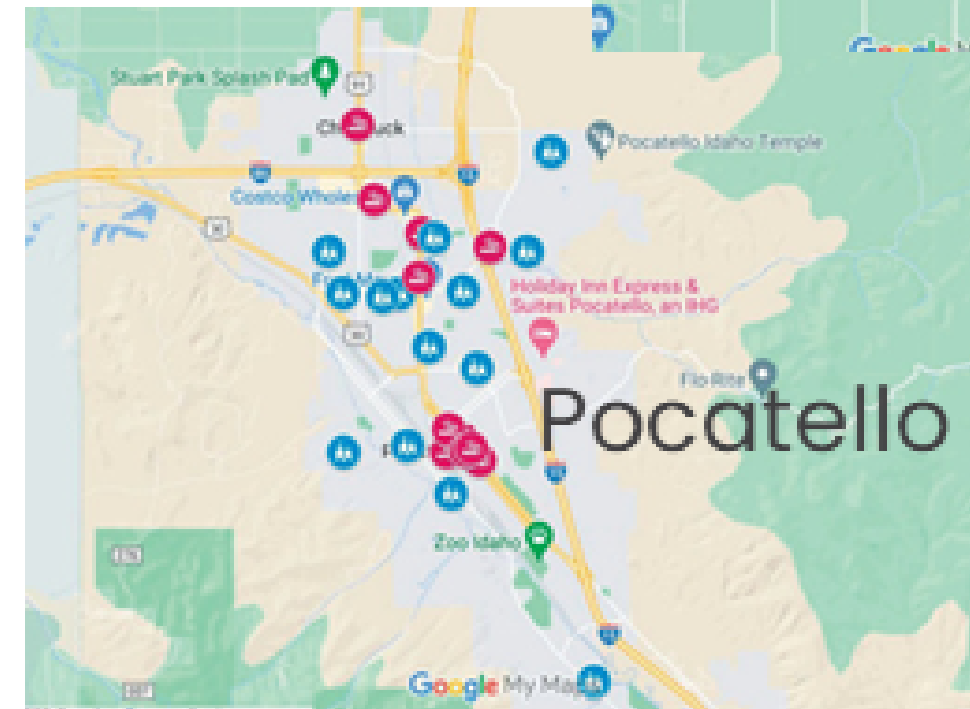
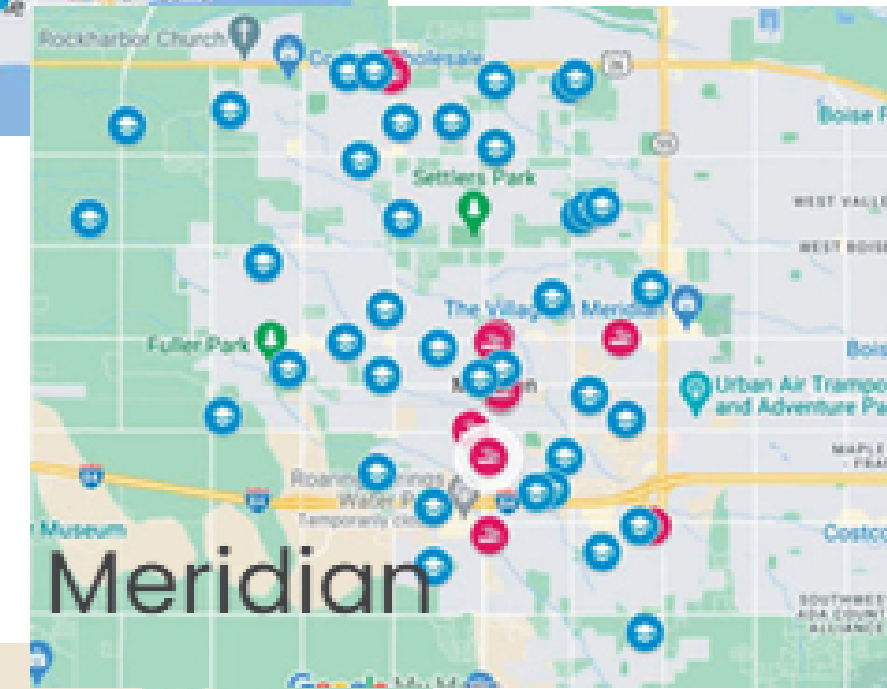


Priority Issues

- 1** Ensuring Access to Quality Care - State
- 2** Reducing the Toll of Tobacco - State
- 3** Multi-cancer Early Detection Screening Act - Federal

Questions

Advocacy in Action





Register for Volunteer Training & Cancer Action Day

March 12 & 13, 2023





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Thank You

Setting the Stage:





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Everyone Has A Cancer Story:





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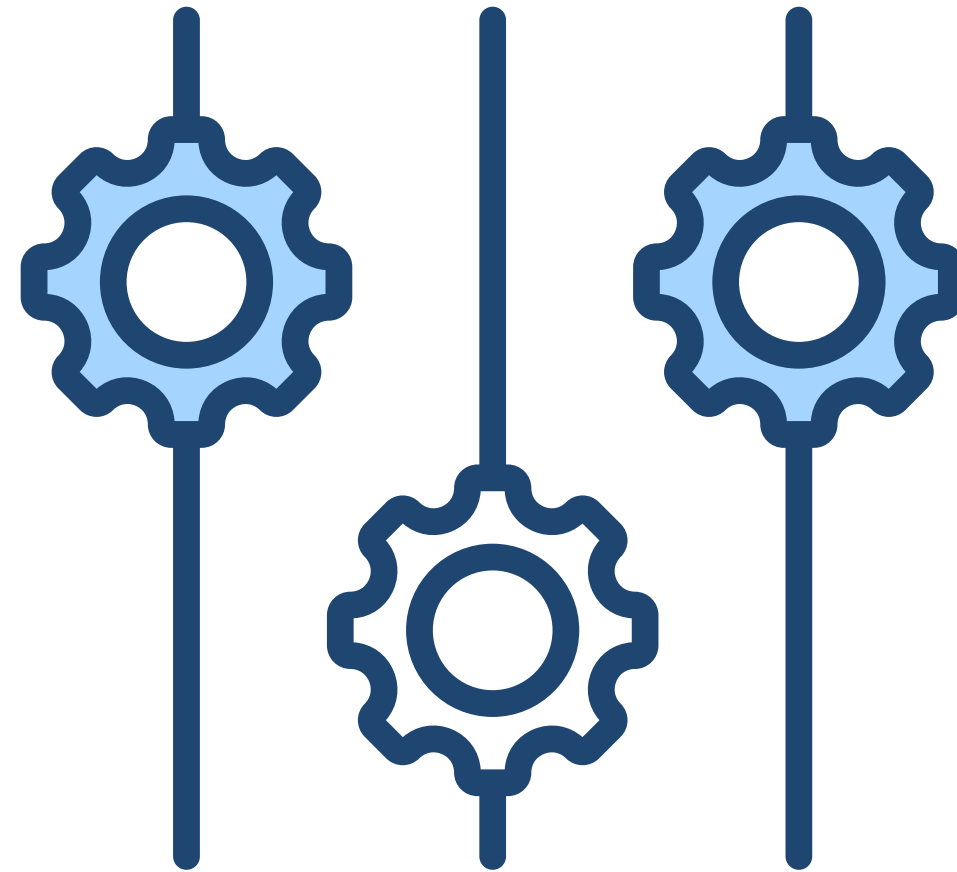
What is your role in the battle to prevent and eliminate cancer?

State Level

Local Health District Level

Within your community

Clinical Level



As an Individual



Thank you for Attending!

For more information or if you are interested in joining CCAI or the Board please reach out to Brie.Veltri1@dhw.idaho.gov

Please Stay for Networking Lunch