PCC NEWSLETTER

PREVENTING COLORECTAL CANCER

Also known as the National Coalition for Quality Colorectal Cancer Screening and Care

SUMMER 2011

Opportunities for Healthcare Cost-Cutting

Steven J. Morris, MD, FACP, board chair president, Atlanta Gastroenterology Associates

In today's world of budget cuts and the fact that the United States' credit card is nearly maxed out, it's time to look at real ways to improve healthcare delivery. Medicare and Medicaid funds are drying up and we're only beginning to see the baby boomers' impact; it's only going to get worse. We know there is a problem, but there have been no actionable plans to fix anything. I find myself frustrated and perplexed that my efforts to bring costs down and take care of my patients in a cost-effective manner are often either blocked, ignored, prolonged or impossible to initiate.

Steven J. Morris, MD, FACP

Here are four simple examples:

I run a very large gastroenterology group with multiple outpatient centers. We recently built an eighth

See Healthcare Cost-Cutting, page 5

Why Do Both Patients and Providers Prefer Propofol?

Q&A with PCC board vice chair, Stanford Plavin, MD

PCC's Regan Weaver had a chat with PCC board vice chair, Stanford Plavin, MD, to gauge his perspective on the widely used sedation/anesthetic agent, propofol. The drug received a great deal of negative press after the accidental death of Michael Jackson during the summer of 2009. It enlightened many as to the consequences of inappropriate administration of a drug of this caliber in the wrong setting.

Propofol is widely considered the agent of choice for many procedures/operations, including colonoscopy, and is a carefully monitored and administered medication due to its "black box" warning. While the warning seems cumbersome and daunting; patient safety is a valid concern. The FDA deems many controlled substances worthy of this designation, although FDA has not yet ruled the drug a controlled substance.

PCC: From the patient's perspective, what makes propofol preferable to other sedation options?

Procedures in general—let alone colonoscopy—provoke many concerns and anxieties for patients.

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In this issue...

LEGISLATIVE UPDATE

Department of Defense Appropriations Act Contains Colorectal Cancer Research Funding

By a bi-partisan vote of 336-87, the U.S. House of Representatives passed the 2012 Department of Defense (DOD) Appropriations Act that included the important Congressionally Directed Medical Research Program (CDMRP) to provide federal financial support for colorectal cancer research. This Act provides funding for $332 million of cancer research, and specifically sets aside $12.8 million in colorectal cancer research funding for the coming year.

This is the second year that CDMRP funding has included colorectal cancer research funds, and PPC was directly involved in gaining passage. Along with 128 other advocacy groups, PCC worked to convince members of the House to approve this important cancer research funding.

You might wonder why Congress is providing funding to the U.S. military for cancer research. The DOD spends over $1 billion per year to cover medical care for its members who are diagnosed with various forms of cancer. The intent of the CDMRP funding is to seek out innovative research opportunities that can have a favorable impact on that cost.

The 2012 DOD Appropriations Act is now set to move to the Senate. The debt ceiling compromise has been signed into law by President Obama, and this debt compromise may drive a newfound interest in controlling spending. We will need to redouble our efforts to see that this colorectal cancer research funding is preserved in the Senate version of the 2012 DOD Appropriations Act.

In the longer term, the recent debt compromise contains triggers that will cause automatic spending cuts if significant spending cuts do not materialize. These automatic triggers include cuts to DOD spending authorizations. It is too early to tell if this will impact the CDMRP research funds. PCC will have to increase its advocacy efforts if we expect to preserve this research funding. Only time will tell.

If you would like to see how your lawmaker voted on the DOD Appropriations Act, visit *http://clerk.house.gov.*

Your efforts can make a difference. Take a few moments and share your thoughts with your senators on the value of this CDMRP research funding and the opportunities it represents to make a difference in the fight against colorectal cancer. Colorectal cancer is the second greatest cause of cancer deaths in this country. We can beat this dreaded disease, but it will take funding for research. Contact your lawmakers and make a difference.

If you would like to contact your senators to advocate this colorectal cancer research funding, go to *http://www.senate.gov/general/contact_information/senators_cfm.cfm.* •

IN THE NEWS

CRC Screening Rates Improve When Patients Use Navigator

A recent study published in the May issue of *Archives of Internal Medicine* found that those who had the help of a healthcare "navigator"—a community member who guides individuals through various aspects of the healthcare process—were much more likely to be screened for colorectal cancer. After assessing 465 primary care patients, researchers found that rates improved the most for minorities and the underprivileged.

For the full story, visit *www.medpagetoday.com/gastroenterology.* •

Early Chemo an Effective Post-Surgery Treatment

For every month that chemotherapy is delayed following the first four weeks after colorectal cancer surgery, a patient's odds of survival decrease considerably, according to a recent Canadian study published in the *Journal of the American Medical Association*. The study states, "What we found is that roughly for every month delayed, chemotherapy is 14 percent less effective in improving survival rate," said Dr. James J. Biagi, the study's lead author.

To read more, visit *www.health.msn.com/health-topics/colon-cancer.* •

SPOTLIGHT ON ADVOCACY

Confronting Colorectal Cancer at a Young Age

By Stephanie Carneal

Editor's Note: *Stephanie Carneal is a senior at Indian Creek Upper School in Crownsville, MD. She served as an intern for Schooner Healthcare Services this summer. She enjoyed researching this topic, which "opened her eyes to issues that impact people not much older than I am."*

Imagine thinking that one second you have your whole life ahead of you, and then the next finding out you might die at an early age. This is a reality that confronts many patients newly diagnosed with colorectal cancer (CRC) especially, those that are found to have the disease at a young age.

Often times, young adults with this form of cancer are diagnosed in the later stages of the disease due to the fact that routine colonoscopies are not performed on people under the age of 40. Even if a younger person is exhibiting all of the key systems of CRC, doctors may not think that the symptoms are caused by cancer and may neglect to perform this test.

Cancer is the fourth leading cause of death in young adults. Although rare, colorectal cancer rates continue to increase in young adults between the ages of 20 and 34. There is a direct correlation between increased survival rates and the swiftness in recognizing the disease and treating it. Due to delayed diagnosis, colorectal cancer is usually found in much later, more deadly stages in the younger demographics. The fact that younger people are diagnosed in the later stages of the disease needs to be acknowledged, and more specialists are a necessity.

According to a National Cancer Institute report, "Even as cancer survival rates continued to improve in adults of middle age and older, the survival rates for people ages 15 to 39 has not risen substantially in more than two decades."

The fact that doctors overlook the key symptoms of colorectal cancer in the younger demographics, and neglect to perform a test that would be routine if the patient was older, is a serious problem that needs to be addressed. More research is needed to understand why colorectal cancer rates are on the rise among young adults.

It is not unusual for someone to be misdiagnosed with CRC. In fact, it is unusual for a doctor to suspect cancer is the problem in certain age groups. Molly McMaster is a prime example of misdiagnosis. Molly had excruciating abdominal pain for a few months and was told by her doctor it was merely constipation or Irritable Bowel Syndrome.

Molly was admitted to the hospital for a total blockage in her large intestine, and underwent surgery. The doctors removed a tumor the size of two fists. At the age of 23, on her birthday, Molly McMaster was diagnosed with stage two colorectal cancer.

Molly is lucky enough to be a cancer survivor. In an effort to raise awareness of the disease that could have taken her life, Molly has developed a website called *www.colonclub.com* featuring "crazy projects" to raise money and awareness of the disease. The first project of The Colon Club was the Colossal Colon®, a 40-foot long, 4-foot tall crawl-through replica of the human colon that has been touring the United States since 2002.

> *It is extremely important to educate people about colon cancer, and the possibility of it happening to them, regardless of age.*

Molly realizes that not all people diagnosed with colorectal cancer are as lucky as she is. Like Molly, some patients were misdiagnosed prior to discovering that cancer was the actual problem.

Early detection is the key to increasing survival rates in patients with colon cancer. It is extremely important to educate people about colon cancer, and the possibility of it happening to them, regardless of age.

Colorectal cancer is frightening news for anyone, especially someone embarking on life's journey. People diagnosed with the disease can find support by connecting with others who are also dealing with the disease as well as reaching out to friends and family.

Publicizing the need for early detection will hopefully reduce misdiagnosis and fatalities due to this form of cancer, improving the alarming statistics we see today. •

PROPOFOL

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In fact, patients tend to avoid experiences out of fear of pain and the potential outcomes of the test. Conscious sedation, in which a patient receives a cocktail of narcotics and benzodiazepines, tends to result in patients being more "awake" for the procedures. Plus, some of the side effects are problematic. This practice is still widely used.

When anesthesiologists provide monitored anesthesia care with the use of propofol for colonoscopy, they find the patients are more deeply sedated and have a faster recovery profile.

When anesthesiologists provide monitored anesthesia care with the use of propofol for colonoscopy, they find the patients are more deeply sedated and have a faster recovery profile. This enables patients to embrace the use of propofol and encourage those sitting on the fence to get their screenings and tests done. The expectations of today's patients and society have changed dramatically in the United States and this sedation option provides a much better choice.

PCC: The drug is also popular with gastroenterologists. Why?

As an anesthesiologist answering this question, I am a bit biased. I am a patient advocate and so are the gastroenterologists. The use of propofol in the endoscopy suites, hospitals and ASCs has provided a much improved sedation experience for the patient, allowing the gastroenterologist to focus exclusively on the procedure and less on concerns about the patient's vital signs and comfort. In addition to improving the overall efficiency of many facilities, propofol sedation in GI has been found to be associated with increased rates of polyp detection during exams, higher colon completion (cecal intubation) rates, as well as improved patient satisfaction.

PCC: Headlines in 2010 publicized the shortage of propofol. What's the latest?

The shortage isn't nearly as bad as early 2010. Hospitals and most surgery centers have what they need to provide care to patients. Some pockets of shortage remain in certain areas, but this is the exception right now. The shortage of 2010 spurred many anesthesiologists to get creative and find other treatments and medications during procedures. It makes one realize how sacred the use of propofol is. The FDA, ASA, AMA and other organizations are striving to improve drug shortage issues in general. The main reason there was a shortage in 2010 was because a major manufacturer exited the marketplace and another manufacturer had production issues. The medication is still considered relatively inexpensive by today's standards, as a generic bottle of 20mls sells for less than $5.

The use of propofol is now, and has become, the standard agent used for endoscopy/colonoscopy. PCC continues to support this level of care for its patient advocacy campaign as delivered by anesthesiologists and qualified anesthesia personnel. •

Researchers Identify Probable Colorectal Cancer Marker

Researchers at Children's Hospital Boston say they've found a marker called ABCB5 that exists in high proportions within colorectal cancers. As a result, eliminating cells that express ABCB5 is key to the success of colorectal cancer treatment. After studying both healthy and cancerous colorectal tissue, researchers concluded that ABCB5 exists in cancerous tissue at levels 23 times higher than it exists in healthy tissue.

To read the full article, visit *www.sciencedaily.com/releases.* •

HEALTHCARE COST-CUTTING

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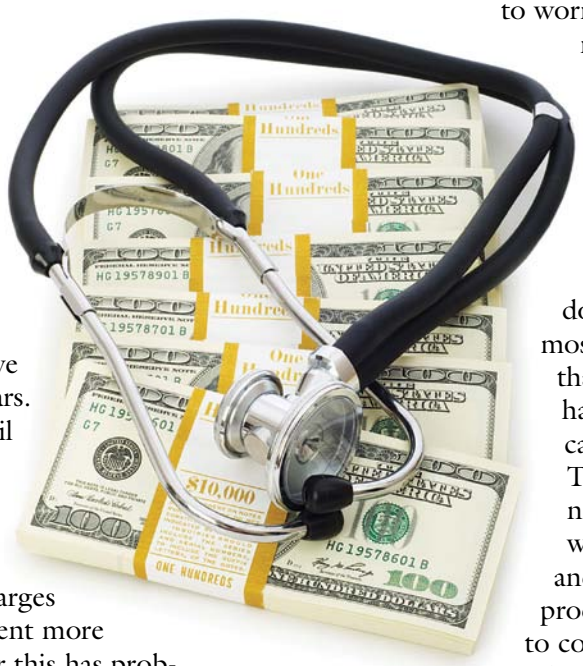
center in Northwest Atlanta, adjacent to one of the largest hospitals in the state. Despite AAAHC and Medicare Certification, we have been open 15 months and are still awaiting a contract from one of the two largest insurers in the state. The contract is exactly the same as we have at our other seven sites and we have had those open for up to 15 years. Endless paperwork, months until we can get a reply to requests, errors in the contract, and no sense of urgency results in our doctors doing cases everyday in the hospital facility, which charges patients from 300 to 1000 percent more than our facility. In the past year this has probably cost that provider millions of dollars; so in turn, they raised their premiums an average of 15 percent so they could report record earnings.



Another example of the healthcare industry lacking cost-effective policies occurs when administering infusions of a drug called Infliximab, which we have continued to do in our offices for patients with Inflammatory Bowel Disease. Because of razor-thin margins using this expensive drug, many of my colleagues have started sending these patients to the hospitals for treatment, which averages about once every eight weeks. How do the insurers respond? Naturally, they cut my fees. So now we can send the patients to the hospitals that receive between $12,000 to $18,000 per infusion in Atlanta and up to $30,000-plus per treatment in other parts of the country. In-office payment is usually less than $3,500. Same drug, same dose, same patient—four to tenfold difference. The cost to Blue Cross if we stop infusing equates to over $10 million a year. Not to worry, they raised our insurance rates 18 percent.

> *I read about how much healthcare costs, but I see tens, if not hundreds of millions of dollars, thrown away every year on things that make no sense and are easily changed.*

If you are not frustrated yet, consider 'double' procedures—my favorite waste of time, resources and money. Medicare has long taken a posture of only paying half for a second procedure done the same day. Therefore, most commercial insurers follow that policy. So how do doctors handle this? We execute the cases on two separate days. This means that a patient will need to take twice the time off work, there will be two facility and anesthetic fees, and loss of productivity. I have tried to explain to congressmen, medical directors, and insurance company executives how much money could be saved by paying fairly for both procedures even if done the same day. It falls on deaf ears.

Finally, the most irrational part of healthcare is that if you go to the hospital, emergency room or even certain doctor's offices and you have no insurance or a high deductible (i.e., catastrophic policy), you pay the highest price. If you go to buy a car, furniture, a personal service (such as construction) and can pay cash, do you get the worst price? No, only in healthcare do you get the most perverse result. Cash is not king—it is a ticket to get ripped off.

I read about how much healthcare costs, but I see tens, if not hundreds of millions of dollars, thrown away every year on things that make no sense and are easily changed. However, record earnings, double-digit insurance rate raises (30 percent or more in California), multi-million dollar salaries for insurance executives and hospital administrators, and doctors who don't worry about costs, all coalesce to suppress any real desire for change.

Let's hope for some changes—for patients, for providers, for our country. •

Raising Screening Rates with Grassroots Coalitions

Across the nation, colorectal cancer screening rates are on the rise. However, room for improvement remains as one in three adults over the age of 50 still has not received any method of screening.

According to a recent survey conducted by the Colon Cancer Alliance (CCA) and Quest Diagnostics, a major contributor to people being screened is having the procedure recommended by their primary healthcare providers. Among men and women over 50 who have not been screened for colon cancer, more than one in four (28 percent) said their healthcare provider, such as a doctor or nurse, did not recommend the screening. It is interesting to note that of the survey respondents who said they were aware of screening guidelines, 54 percent of them cited family and friends as the source of their knowledge.

These findings from the CCA/Quest survey lead us to believe that a grass-roots effort to raise awareness is nearly as important as primary care physician's referrals. The Center for Disease Control (CDC) has had a very successful advertising campaign with luminaries such as Terrence Howard and Katie Couric providing their image and personal stories for the posters you can see all over America. Likewise, radio programs and celebrity doctors such as Doctor Oz (on the Oprah show no less!) have been doing their part to raise awareness of this preventable cancer.

In South Carolina, the Center for Colon Cancer Research not only spends time and effort on scientific endeavors to reduce the incidence of colon cancer, they also fund programs across their state, which raises awareness within the general population. Their 'We Can!' program provides free colon cancer awareness and educational programs to individuals and groups (such as churches and civic organizations). It also can supply a free exhibit suitable for health fairs and community events, information on where to get screened for colon cancer, and help getting screened for colon cancer through community navigation. Programs such as this one in South Carolina should be emulated across the nation to truly improve the screening rates and awareness of colorectal cancer.

For the Quest Diagnostics survey, visit *http://www.ccalliance.org/pdf/ColonCancerScreeningSurvey-ReportSummary.pdf.* •

FOR MORE INFORMATION

To stay updated with the latest news, email *info@preventingcolorectalcancer.org* to join the mailing list or learn about the benefits of membership.

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