AMGA™

Advancing High Performance Health

Colorectal Cancer Screening

Quality and Innovation Collective (QuIC)

Phase 1 Meeting Summary

Colorectal Cancer Screening

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For Phase 1 of the Colorectal Cancer Screening Quality and Innovation Collective (CRC QuIC), AMGA hosted a 90-minute virtual forum on April 29, 2021. The meeting was moderated by Megan Romine, D.O., FACP, UnityPoint and sponsored by Exact Sciences. Representatives from eight AMGA member health systems and medical groups were in attendance, including Geisinger Health System, Henry Ford Health System, Mercy Health System, Premier Medical Associates, Prevea Health, Revere Health, Sutter Valley Medical Foundation and Watson Clinic. The participants engaged in an interactive discussion on colorectal cancer (CRC) screening to explore barriers and successful strategies to overcome them. Attendees ranged from primary care physicians and nurse practitioners to quality, medical, and financial leaders.

The virtual discussion started with attendees sharing successes in their CRC screening work. The moderator and attendees focused the majority of the discussion on the top four ranked problems: lack of patient awareness and education about CRC screening and prevention; evaluating individuals 45-75 years old; disparities in care; and clinical workflow.

While many of the organizations shared that they saw a decrease in their CRC screening rates over the last year due to COVID-19, Sutter Valley Medical Foundation was able to maintain rates above the 90th percentile nationally. Sutter focused on closing the healthcare disparities screening gaps for their cancer patients, including CRC. Because of this work, they successfully closed the gaps between the White/Caucasian populations and the Black/African American populations by 5-6% by end of last year.

Revere Health's CRC screening rate is now over 80%. They have seen an increase in patients returning for their repeat screenings and believe it is a result of patients feeling less nervous about coming into a medical facility to receive medical care as the pandemic impact wanes. Kathy Zeyer, Revere Health, said, "A high note is seeing people being motivated and taking responsibility for their care and following up."

Other organizations shared that while their CRC screening rates dipped slightly during the pandemic, they are proud to have remained in the 75% to 90% rating, nationally. Another organization maintained their Five-Star Quality Rating for CRC screening throughout the pandemic.

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AMGA and forum moderator Dr. Romine worked together to identify eight problems or motivating needs that healthcare organizations may encounter with CRC screening. The identified problems or motivating needs are among the most important elements of successful CRC screening. Prior to the forum, attendees were asked to rank all problems from the list ("1" most important to "8" least important). See table below for responses.

Problem List	Number of Respondents	Average Score (Based on number of respondents)	Problem Rank
Lack of patient awareness and education about colorectal cancer screening and prevention. (Includes shared decision making.)	8	3.3	1
Evaluate individuals 45-75 years old	8	4.0	2
Disparities in Care	7	4.0	2
Clinical workflow	7	4.1	4
Knowledge deficit of colorectal cancer screening and cancer prevention	8	4.3	5
Lack of timely follow-up after an abnormal CRC screening	7	4.6	6
Lack of screening and identification of patients at average risk and high risk for colorectal cancer	7	5.0	7
Information Technology support	6	5.2	8

#1 Problem: Lack of patient awareness and education about CRC screening and prevention.

Four organizations in attendance ranked lack of patient awareness and education about colorectal cancer screening and prevention in their top three problems/motivating needs (Revere Health, Geisinger Health System, Watson Clinic, Prevea Health).

It was a consensus among the attendees that there is an overwhelming lack of patient awareness about colon cancer, and patients fear a colonoscopy and lack awareness of other screening options. "Patients generally do not understand that colon cancer screening is actually colon cancer prevention," said Diane George, D.O., Henry Ford Health System.

Revere Health has made efforts to educate patients and make them more aware of colon cancer. Most of the lack of patient awareness and education stems from public perception. Colon cancer is not top-of-mind for many patients, and it does not get as much PR or marketing attention as breast cancer and other types of cancer. About 10 years ago,

a popular Utah newscaster passed away from colon cancer. Shortly after, the state conducted a CRC public awareness campaign featuring the newscaster's daughter saying, "If my dad only got screened." Afterwards, Revere Health saw an increase in screenings. However, interest eventually wore off, highlighting the need for promoting continued awareness about CRC screening among patients. Revere Health has since created digital marketing campaigns.

Additionally, they are providing written materials for their primary care offices, ensuring medical assistants and other staff are well informed when having conversations about CRC with patients. Their medical group has also been successful with holding all practices accountable for getting patients screened, including both primary care and specialties. Through a dashboard in their electronic medical record (EMR), they are able to pull reports that shows patient quality gaps, including for CRC screening. With that data, specialty departments are able to address care gaps at the point of care.

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Amy Luzier Barrett from Geisinger Health System described that some patients are fixated on the preparation and procedure. Patients automatically refused the screening without understanding the options. However, when they learn what is involved, many times patients see that the screening procedure is not as bad as it seems. Additionally, Geisinger Health System has seen an increase in screening rates when offering Cologuard at-home screening as another option to colonoscopy.

Sutter Valley Medical Foundation's experience is less about lack of awareness and more about patient hesitancy to getting the fecal immunochemical test (FIT) test done including the time and inconvenience of the collection and return procedure. One successful strategy is to make things as easy as possible for their patients by making FIT test kits available in the physician office, eliminating a trip to the lab. When patients receive the FIT test kit, it includes a preaddressed and pre-labeled return envelope. Another impactful strategy is Sutter Valley Medical Foundation's centralized team which provides outreach to many of their patients and focuses on priority populations. The centralized team consists primarily of medical assistants (MA) and those with patient service representative experience. They also have a few registered nurses (RN) and licensed vocational nurses (LVN) on the team. Per Sutter Valley Medical Foundation's policy, RNs can sign health maintenance orders generated by the team. Finally, over the last several years, Sutter Valley Medical Foundation has also incorporated CRC screening as one of their value-based compensation measures for internal medicine and family medicine providers.

#2 Problem: Evaluate individuals 45-75 years old.

Two organizations in attendance ranked evaluate individuals 45-75 years old in their top two problems/motivating needs (Premier Medical Associates, Revere Health).

In response to plans for outreach to the proposed lower screening age of 45, James Rogers, M.D., FACP, at Mercy Health System discussed the lack of knowledge among primary care providers about the out-of-pocket cost of the colonoscopy procedure for the patient, which can affect informed shared decision making. Mercy Health System considers all of the costs to the patient, including the prep for the procedure, time off from work, and the need for

having a designated driver. In response to these concerns, the organization has started a new campaign called "Normal Risk, FIT First." The patient can elect to purchase a less expensive screening test on Amazon and report the results to the healthcare system, which will place it into their electronic medical record (EMR). This strategy would benefit organizations that are moving toward value-based care and capitation. Policies are needed to follow up with a colonoscopy for patients who had a positive FIT Test result. Dr. Rogers discussed the need for education among providers on current screening standards. Also mentioned was an informed decision and informed direction approach. With Informed direction the provider guides the patient who is at normal risk to get a FIT test every year and if positive to get a colonoscopy. This approach is cost effective and easy to accomplish.

#3 Problem: Disparities in Care.

Four organizations in attendance ranked disparities in care in their top three problems/motivating needs (Prevea Health, Revere Health, Geisinger Health System, Sutter Valley Medical Foundation). Sondra Hillberg, RN, Prevea Health, stated, "We struggle in this area for our very rural population. We have tried providing education. We find that lack of transportation is a huge barrier."

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Sutter Valley Medical Foundation decided to look into the significant gaps with their African American population by stratifying their list of patients who need CRC screening differently. This has helped improve screening rates, and they are doing outreach to prioritize getting African American patients in for visits. In addition, Sutter Valley Medical Foundation is looking into their Hispanic population gap. They have not had a good response with translation services; however, they do see good outcomes when utilizing a Spanish-speaking staff member for outreach. They are also pursuing Spanish language education materials.

Diane George, D.O., Henry Ford Health System, shared that they have a relatively new equity dashboard. They are tracking race, ethnicity, primary language, and gender. She said, "The equity dashboard is an eye opener with regards to our African American population. Colon cancer is a disparity with this population."

#4 Problem: Clinical workflow.

Four organizations in attendance ranked clinical workflow in their top three problems/motivating needs (Sutter Valley Medical Foundation, Mercy Health System, Henry Ford Health System, Watson Clinic).

Geisinger Health System does not have a standardized workflow across all specialty departments. Primary care has nursing protocols that enables nurses to address Best Practice Alerts that identify patients in need of a CRC screening test. They also have scripts for the providers and nurses. Nurses have standing orders that allow them to place orders for the test or procedures. Once the orders have been placed, it becomes the responsibility of the specialty department, such as gastroenterology or general surgery to complete the screening procedure. A lack of communication among departments is a challenge and results in gaps where patients are not following through with a test or procedure and the primary care physician office is not informed.

Question: What else would you like to tell us about regarding your CRC screening work?

Following discussion on the top four ranked problems or motivating needs, attendees were encouraged to share other top-of-mind issues or experiences with CRC screening.

Frank Colangelo, M.D., FACP, MS-HQS, Premier Medical Associates, ranked "lack of timely follow-up after an abnormal CRC screening" problem highly. He shared that there is a "huge problem with lack of follow-up. There are several barriers to take into account. Maybe the patient wasn't notified or the patient didn't realize the significance and wasn't educated about it either."

Attendees engaged in discussion around the issue of payers seeing colonoscopy as diagnostic, if it was done after another screening test (like Cologuard). James Rogers, M.D., FACP of Mercy Health System encourages doctors to work with their practice coding and billing specialists and payers to determine if colonoscopy following positive FIT or FIT-DNA testing may be considered completion of the screening test rather than a diagnostic procedure.

Conclusion

Overall, attendees were inspired and encouraged by the novel ideas shared during the forum.

Sondra Hillberg, RN, Prevea Health, stated that she is "excited by the ideas shared and wants to get everyone at the organization talking about these screenings."

Addendum

#1 Problem: Lack of patient awareness and education about CRC screening and prevention.

Probes: Why did you rank the problem this way? Why is this a top-ranked problem in your organization, above all/most others? What are successful strategies to address this problem? What is your process for patient outreach? Do you utilize education? National CRC screening guidelines from the United States Preventive Services Task Force (USPSTF) and the American Cancer Society (ACS) recommend patients should be given a choice in screening options. How well has your system implemented these recommendations? Describe the extent and specific activities you use for utilizing a choice-based shared decision-making approach with patients. What impact has a true choice-based approach had on your system's screening efforts?

#2 Problem: Evaluate individuals 45-75 years old.

Probes: Why did you rank the problem this way? Why is this a top-ranked problem in your organization, above all/most others? What are successful strategies to address this problem? USPSTF recently released a draft version to update their CRC screening recommendations. In this draft, the proposal is to lower the screening age to 45 (similar to what is already recommended by the ACS). While not final, should this become the new recommended age for CRC screening? What efforts would your system implement to reach this younger age group for screening?

#3 Problem: Disparities in Care.

Probes: Why did you rank the problem this way? Why is this a top ranked problem in your organization, above all/most others? What are successful strategies to address this problem?

#4 Problem: Clinical workflow.

Probes: What are successful strategies to address this problem? Do you have a standardized clinical workflow for CRC screening?

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