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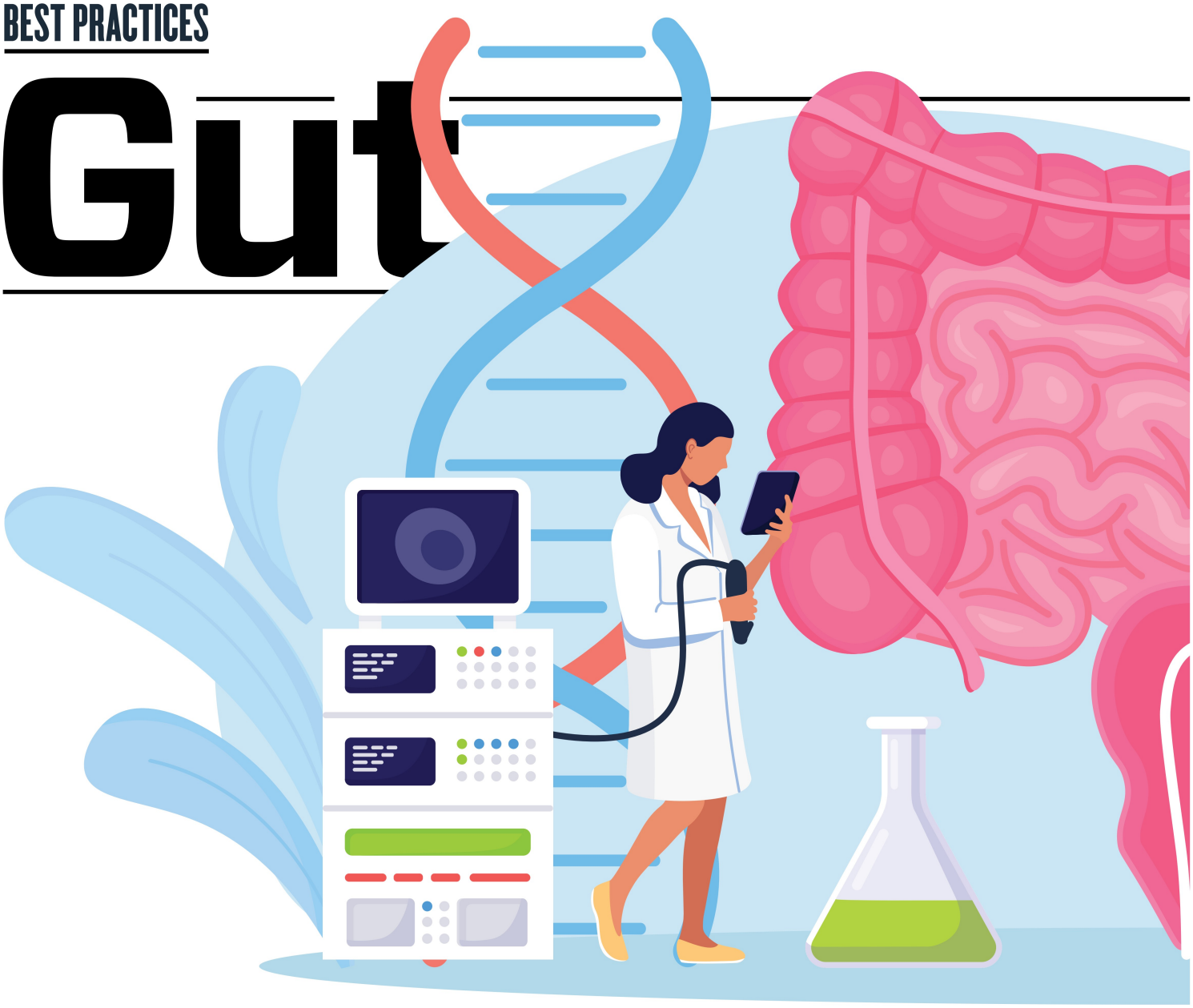

Partnering to improve CRC screening

By Francis Colangelo, M.D., M.S.-HQS, FACP

Colorectal cancer (CRC) is the second-leading cause of cancer death in the U.S. when men and women are combined, yet screening can prevent many cases through the detection and removal of precancerous growths. Screening can also detect CRC at an early stage, when treatment is usually less extensive and more successful. Plus, patients have screening options—a colonoscopy is not the only test for CRC screening. Simple, affordable options are available, including tests that can be done at home.[1]

As we like to say at my organization, Premier Medical Associates, the best test is the one that gets done.

Approximately 4.2% of men (1 in 24) and 4% of women (1 in 25) will be diagnosed with CRC in their lifetime. In 2022, an estimated 151,030 people will be diagnosed with CRC in the U.S., and 52,580 people are expected to die from the disease.[1]

Despite these options, nearly 1 in 3 adults ages 50 and older are still not getting screened as recommended.[2] Plus, there are now more screening-eligible adults than ever since nearly all major guidelines now recommend screening for average-risk individuals begin at age 45 and continue through at least age 75.[3,4] Yet, we've seen decreased CRC screening rates due to the pandemic, and persistent and unacceptable

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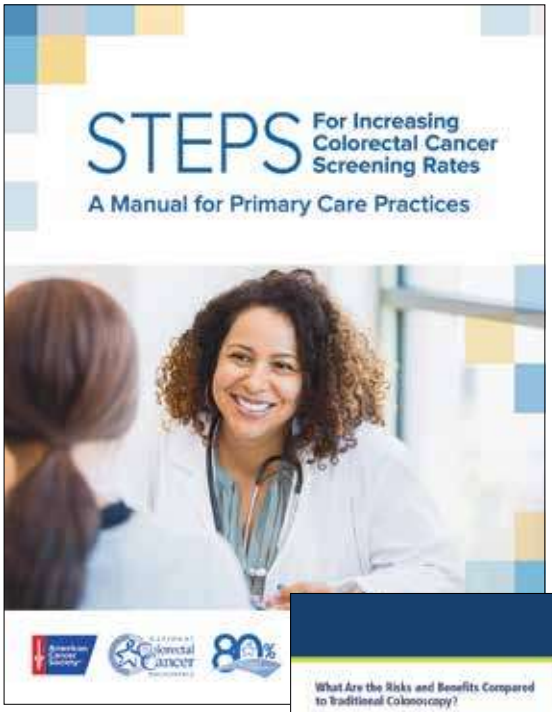
CRC screening and outcome disparities are only being exacerbated in racially and ethnically diverse, socioeconomically challenged communities across the country.

The good news is there are new tools available to support your work to screen more patients for CRC, and AMGA and other national organizations are strengthening their focus on supporting health systems in their efforts to increase on-time CRC screening. I am proud to have been a part of AMGA's Collaborative for Performance Excellence (CPX), which was active in 2020–2021 and included a focus on improving CRC screening rates. More recently, AMGA hosted a Colorectal Cancer Screening Quality and Innovation Collective (CRC QuIC) in 2021–2022 that brought together 12 AMGA member organizations. This work is described in more detail below.

Partnering with the National Colorectal Cancer Roundtable

I am also a steering committee member of the National Colorectal Cancer Roundtable (NCCRT), a national coalition that was established by the American Cancer Society (ACS), in partnership with the Centers for Disease Control and Prevention, in 1997 (**nccrt.org**), the first of six mission-critical, cancer-focused national roundtables for which the ACS provides organizational leadership and staff support. The NCCRT comprises more than 150 membership organizations, including government agencies, health systems, professional societies, nonprofit groups, corporate associates, and more, all of whom work collaboratively to reduce the incidence of and mortality from CRC in the U.S., through coordinated leadership, strategic planning, and advocacy. The ultimate



Providers are encouraged to download an extensive suite of patient-friendly information around colorectal cancer screening from the NCCRT website and AMGA's CRC QuIC web page.

goal of the NCCRT is to increase the use of recommended CRC screening tests among the entire population for whom screening is appropriate.

As part of this mission, the NCCRT launched the 80% in Every Community initiative, which aims to ensure that CRC screening rates reach and exceed 80% in communities and organizations across the nation. Since 2014, more than 1,800 organizations—including health plans, medical professional societies, academic centers, survivor groups, government agencies, cancer coalitions, cancer centers, and many others—have committed to making this goal a priority.

Numerous AMGA members are already engaged with the NCCRT, with a few being recipients of the NCCRT's prestigious 80% in Every Community National Achievement Award (**nccrt.org/what-we-do/80-percent-by-2018/awards**): Sanford Health, Advocate Aurora Health, Phoebe Putney Health, and my own organization, Premier Medical Associates. NCCRT's recent past chair, Richard Wender, M.D., chair, Family Medicine and Community Health, Perelman School of Medicine, University of Pennsylvania, recently served as the keynote at the kickoff to the CRC QuIC in the fall of 2021, and Keith Winfrey, M.D., chief medical officer, New Orleans East Louisiana Community Health Center, my colleague on the NCCRT steering committee, gave the closing keynote presentation in April 2022.

Further, I'm excited to share that AMGA has recently submitted an application to officially join the NCCRT as a member, and I encourage those of you working in medical

groups that are ready to take your CRC screening work to the next level to also consider applying to join.

New Tools to Support CRC Screening

Medical groups can benefit from a suite of clinical support tools available on the NCCRT website (**nccrt.org/resource-center**). In particular, I'm excited to share that the NCCRT recently released an update to their signature primary care practice toolkit: *Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Primary Care Practices* (**nccrt.org/steps-guide**). The original *Steps Guide*, released in 2014, was instrumental in helping primary care practices throughout the U.S. achieve improvements in their CRC screening rates. As an example, Dr. Winfrey's health center credited the guide with providing them with the roadmap to reach and exceed 80%.

The *Steps Guide* includes evidence-based, expert-endorsed recommendations for planning and implementing strategies in primary care practices to improve CRC screening rates. It provides succinct, step-by-step instructions for primary care teams to improve CRC screening and outcomes in practice. Readers will find four important steps: (1) Make a Plan; (2) Identify a Team; (3) Coordinate Care Across the Continuum; and (4) Get Patients Screened. Communication and continuous quality improvement are foundational elements throughout the process.

The *Steps Guide* also includes 10 case studies from exemplary and diverse practices across the country, including seven community health centers and three primary practice groups, all of which are AMGA members: Mercy Health System, Premier Medical Associates, and Sanford Health. Lastly, the appendices serve as a goldmine of field-tested tools, templates, and resources to get you started.

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Early Age Onset Colorectal Cancer

Research now indicates the burden of colorectal cancer is swiftly shifting to younger individuals as incidence increases in young adults and declines in older age groups. An estimated 18,000 cases of CRC (12%) were diagnosed in people under 50 in 2020, with 1 in 4 patients younger than 50 diagnosed with metastatic disease.

Ensure your patients take advantage of potentially life-saving screening as soon as they become eligible—at 45 for patients at average risk or earlier for patients at increased or high risk of the disease. Patients of any age with symptoms should undergo an appropriate diagnostic workup.*

***Learn more about what you can do to assess CRC risk in primary care practices with the NCCRT Risk Assessment and Screening Toolkit to Detect Familial, Hereditary and Early Onset Cancer, at* nccrt.org/resource/risk-assessment-and-screening-toolkit-to-detect-familial-hereditary-and-early-onset-colorectal-cancer.**

*R.L. Siegel, K.D. Miller, A. Goding Sauer, et al. 2020. Colorectal Cancer Statistics, 2020. CA: A Cancer Journal for Clinicians, 70(3): 145-164. Accessed May 26, 2022 at acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21601.

AMGA's CRC QuIC

I found other valuable strategies for improving CRC screening through serving as one of the advisors for AMGA's CRC QuIC. Building on AMGA Foundation's successful Best Practices Learning Collaborative model, AMGA designed the CRC QuIC as another opportunity for member medical groups and health systems to engage in a high-level discussion on CRC screening.

Sponsored by Exact Sciences, the CRC QuIC was implemented in three phases: *Listen* to high-level discussions through a virtual discussion forum; *Share* current care practices through virtual collaborative meetings; and *Create* new models and care paths through interactive workshops. The CRC QuIC participants identified key learnings around problem areas for CRC screening. They provided QuIC Tips for addressing problems and shared implemented and planned interventions.

For instance, one of the problems identified was a lack of screening and identification of patients at average risk and high risk of CRC. Prevea Health offered this QuIC Tip: "It's important to ensure you have a good process for record collection from outside systems if your patients complete CRC screening elsewhere. We learned there were gaps in our process for this, resulting in having to chart scrub many patient charts prior to sending out fecal immunochemical test-immunochemical fecal occult blood test (FIT-FOBT) kits."

Another problem identified was disparities in care. Geisinger offered this QuIC Tip: "Develop an efficient process for social determinants of health (SDOH) screening and data collection of results so you can identify your vulnerable populations. We determined the most effective way to screen SDOH for patients is to use the Neighborly platform as a means to screen patients at primary care visits. The SDOH survey is launched through the Epic EHR and data recorded into an Epic data base."

As an intervention, Geisinger identified patients with open CRC screening gaps who also have SDOH needs, such as transportation, financial security, and lack of social support, and provided appropriate support to close the CRC screening gap. They also created a system for SDOH screening and data collection. Prevea Health addressed disparities by identifying patients who were overdue for CRC screening for more than one year in a rural area and creating a process to mail FIT-FOBT kits directly to patients' homes, which also included education surrounding all other options for CRC screening.

Participants also identified the problem of inadequate clinical decision support tools. Kelsey-Seybold Clinic offered this QuIC Tip: "We expanded our screening compliance to include breakouts to monitor health disparities among various segments of our capitated population. This proves to be an eye-opening exercise, providing an insightful view into the struggles of sectors of our patient population."

As an intervention, Kelsey-Seybold Clinic increased CRC screening compliance by incorporating clinical decision support (CDS) tools within the EHR for screening, compliance, and follow-up. They made a plan to continue MyKelseyOnline (MKO patient portal) outreach to contact screening non-compliant patients, add an MKO message providing the option of FIT kit screening, incorporate the results of home-based testing into discrete data in their EMR, and report on positive FIT results that need follow-up.

These are just a few examples of the findings and interventions resulting from the CRC QuIC. Meeting summaries from all three phases, as well as a QuIC Tips infographic on the organizations' strategies and interventions during the program, are available on the AMGA website (**amga.org/performance-improvement/best-practices/quality-and-innovation-collective/crc**).

CRC QuIC Participants

- **AHS Oklahoma Physician Group LLC dba Utica Park Clinic**
- **Carle Physician Group**
- **Geisinger**
- **INTEGRIS Medical Group**
- **Intermountain Healthcare**
- **Kelsey-Seybold Clinic**
- **Lehigh Valley Physician Group**
- **Maury Regional Medical Group**
- **Prevea Health**
- **Privia Medical Group North Texas**
- **Summit Medical Group, PLLC**
- **Sutter Health**

Be a Part of the National Effort to Increase CRC Screening

The collective action and collaborative efforts of the 80% in Every Community campaign have already achieved tremendous success. Between 2012 and 2018, 9.3 million additional U.S. adults ages 50 to 75 were screened.[5] AMGA medical groups are making impressive progress to increase CRC screening in the communities they serve, but across the country, many communities still have lower CRC screening rates. In the U.S., people less likely to get tested include those who are Hispanic, American Indian or Native Alaskan, Asian or Pacific Islander, men, or 50–64 years of age. Those who live in rural areas, have lower incomes, or have less education also get screened at lower rates.[1]

Now more than ever, healthcare professionals must make sure all eligible patients receive timely recommendations to get screened. I encourage you to make use of the incredible resources available to you:

- Visit the NCCRT website (**nccrt.org**) and download the *Steps Guide* (**nccrt.org/steps-guide**).
- Review the CRC QuIC meeting summaries and QuIC Tips infographic (**amga.org/performance-improvement/best-practices/quality-and-innovation-collective/crc**).
- Get engaged with NCCRT by applying for membership (**nccrt.org/about/roundtable-membership-app**), signing up to receive the NCCRT newsletter, *CRC News* (**nccrt.org/get-involved**), and following NCCRT on social media (**twitter.com/nccrtnews**).

Everyone deserves to live a life free from CRC. By working together and collaborating to share best practices, AMGA, NCCRT, and medical groups across the country can ensure more patients receive a timely recommendation and treatment. Together, we will continue this work until we see every community benefiting from increased CRC screening rates. GPJ

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