AMGA

Advancing High Performance Health

Colorectal Cancer Screening

Quality and Innovation Collective (QuIC)

Phase 2 Meeting Summary

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Colorectal Cancer Screening

In 2021, 149,500 people will be diagnosed with CRC and 52,980 will die from the disease, based on estimates by the American Cancer Society.

Phase 2 Meeting Summary

AMGA Foundation President and AMGA Chief Medical Officer John Kennedy, M.D., opened the September 15-16, 2021, virtual gathering of the Quality and Innovation Collection (QuIC) focused on colorectal cancer (CRC) screening with a call to action for participants: To implement the new CRC screening guidelines, beginning at age 45, and to close health equity care gaps in CRC screening exacerbated by the pandemic. He encouraged participants to share tactics that drive screening rates higher for CRC and elevate the importance of screening for this highly preventable disease. Screening decreases CRC mortality by decreasing incidence and increasing survival.

The September meeting was the second in a three-part series in AMGA's new three-phase QuIC format, which enables participants to:

- Listen to high level discussions in a virtual discussion forum
- Share current care practices through virtual collaborative meetings
- Create new models and care paths through interactive workshops

Keynote

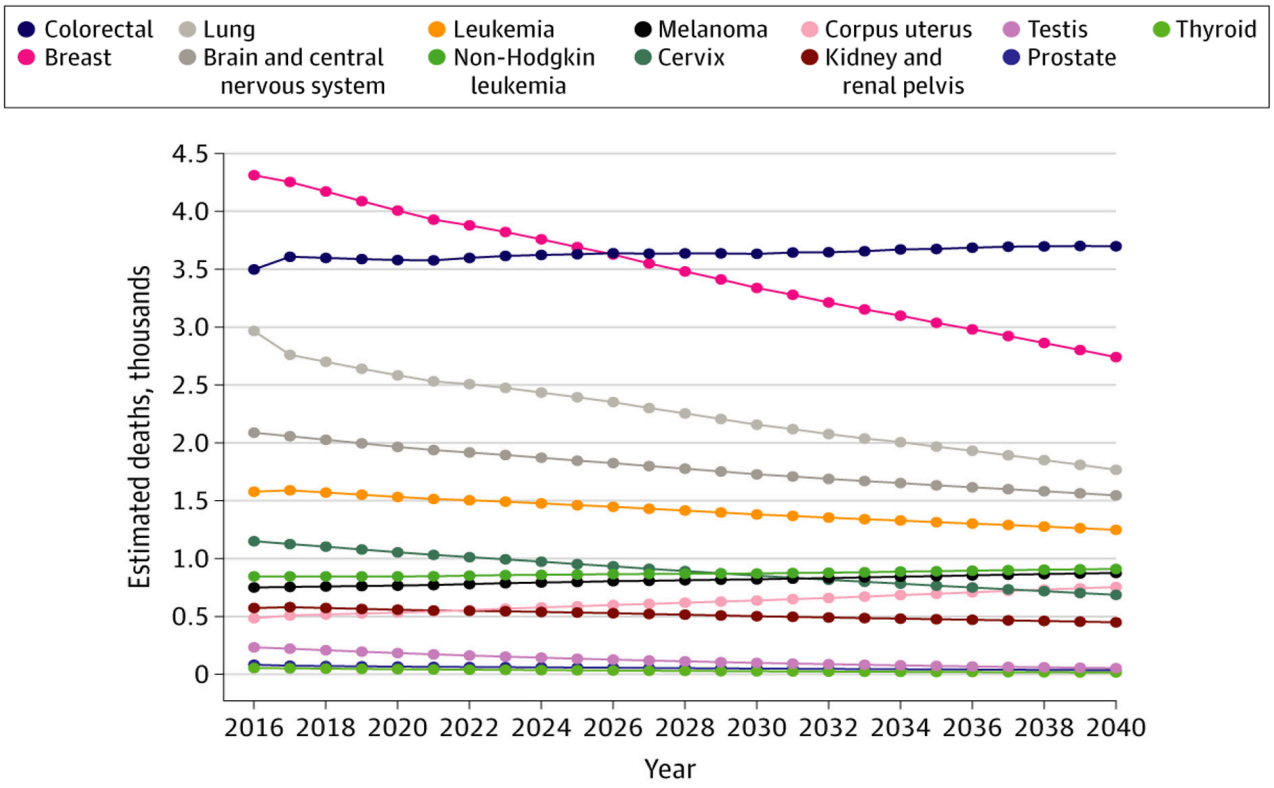
Richard Wender, M.D., *Chair, Family Medicine and Community Health, Perelman School of Medicine, University of Pennsylvania*

CRC may not be the second-leading cause of cancer-related death for long. With persistently low screening rates and rising cases in patients under 50, it's on track to take the top spot, replacing breast cancer, by 2027 (see Figure 1).

September 2021 CRC QuIC Participants

Carle Physician Group
Geisinger
INTEGRIS Medical Group
Intermoutain Healthcare
Kelsey-Seybold Clinic
Lehigh Valley Physician Group
Maury Regional Medical Group
Prevea Health
Privia Health
Summit Medical Group
Sutter Medical Foundation
Utica Park Clinic

Figure 1: Estimated Projection of U.S. Cancer Deaths to 2040, Ages 20-49



Dr. Richard Wender from the University of Pennsylvania talked about ways CRC QuIC participants can help alter this grim trajectory, starting with screening younger patients.

After three years of evolution, all major guidelines now agree: 45 years old is the age to start recommending colorectal cancer screening. Direct evidence supports these guidelines, Wender said, pointing out that adenomas in patients aged 45-49 are biologically identical to those of patients ages 50-54, and that nations such as Austria, which begins screening patients at age 40, have seen decreases in colorectal cancer rates.

Yet several barriers exist here in the United States. Quality measures still start at age 50, mandatory coverage in insurance plans is a year away, and much of the general public still perceives colorectal cancer screenings as something that starts at age 50.

To overcome these obstacles, Wender suggested that organizations start adding reminders in electronic medical records (EMRs) and educating patients on the new guidelines, including copays and coverage.

Given the interconnected nature of all of the above, involving technology, payers, incentives, and more, Wender said, "It really demands a system, it takes a family to get your screening rates up. If you don't implement systemic efforts, you'll have trouble."

Wender outlined common traits of health systems that are high-performing in the colorectal cancer fight:

- **Money** to invest in preventative care. Despite support like U.S. Department of Health and Human Services (HHS) funds, funding has been an enormous challenge during COVID-19, particularly for rural and safety net hospitals. Efforts to prioritize prevention and population management just don't happen when systems are stressed, Wender pointed out.
- **Leadership** providing vocal, informed support in areas like performance incentives, payer contracts, and overall culture.
- **Champions** from experts to innovators to people passionate about the screening mission. Strong champions can make up for lukewarm leadership, Wender said. Make them accountable for progress and make sure they have time to support screening initiatives.
- **Goals**, with progress that is measured and publicly reported.

Diversified screening strategies are another must, Wender said. Because of barriers like transportation access and patient resistance to colonoscopies, organizations have to offer choice. Relying more on at-home fecal immunochemical tests (FIT, Cologuard, etc.) is the only way to catch up with the post-COVID-19 screening backlog and get close to an 80% screening goal, he said.

"The best test is the one that gets done," Wender said.

He pointed out approaches health systems have been taking to improve screening rates: Mailing kits through a centrally managed system, automating instructions for test preparation, eliminating long wait times at clinics, and so forth.

*"Several systems have reduced disparities in **screening**, but disparities in **mortality** still exist."*

— Dr. Richard Wender, University of Pennsylvania

Yet an initial screening is only one step toward lowering CRC mortality, Wender pointed out. Too many patients with an abnormal initial screen fail to pursue the next steps—they do not seek a definitive test and get the polyp removed. Moreover, too many organizations are not measuring follow-up after an abnormal screen.

Prioritize patients with abnormal FIT results for colonoscopies, he recommended. Add follow-ups for positive tests as a category in EMRs and registries for identifying at-risk patients and sending out reminder alerts. And consider a tweak in language for the colonoscopy itself. Positioning the procedure as "completion of the screening process" can improve patient and provider motivation and prospects for reimbursement.

CRC QuIC Overview and Quality Improvement Report

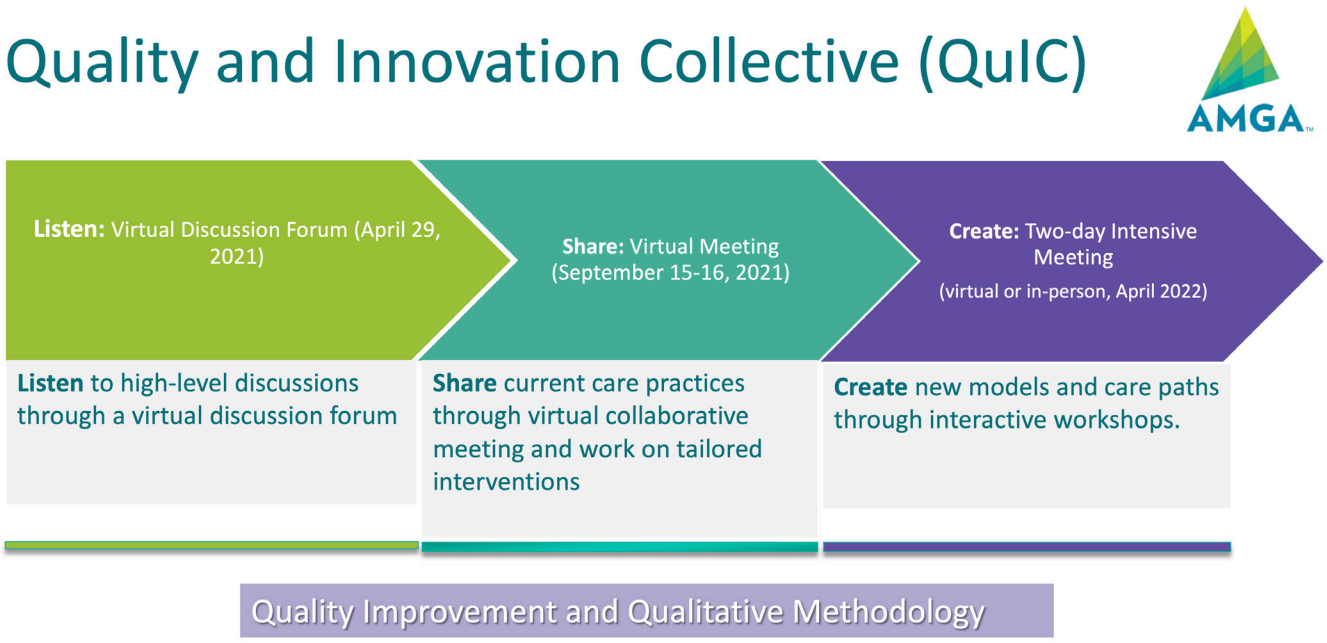
Danielle Casanova, M.B.A., AMGA Foundation senior director, population health Initiatives, set the stage for the next sessions by sharing key takeaways from Phase 1, including an April 2021 virtual discussion forum and member survey identifying top problems and motivating needs around CRC screening.

Not only did screening rates go down due to COVID-19, "there was an overwhelming lack of patient awareness of colorectal cancer and a fear of colonoscopies," Casanova said. Top priorities that emerged were improving outreach to patients age 45-49, closing gaps in disparities, and finding ways to create effective clinical workflows.

These priorities would guide the discussions ahead, Casanova explained: Two days of workshops and breakout sessions to further understand Phase 1 problems and how groups plan to address these problems, with expert advisors available throughout to aid in solution development.

In April 2022, participants will reunite for two days of interactive workshops, discussing specific implemented interventions with the goal of identifying essential and successful strategies to increase CRC screening rates.

Figure 2: QuIC Framework



Using Data to Identify Opportunities for Improvement

Nikita Stempniewicz, M.S., *Director, Research and Analytics, and Meghana Tallam, Associate Population Health Analyst, AMGA*

"Screening is a cost-effective strategy to reduce colorectal cancer prevalence, morbidity, and mortality," Meghana Tallam said as she and Nikita Stempniewicz presented data collected in 2021 from AMGA member organizations' and collaborative participants' electronic health records (EHRs) and billing claims.

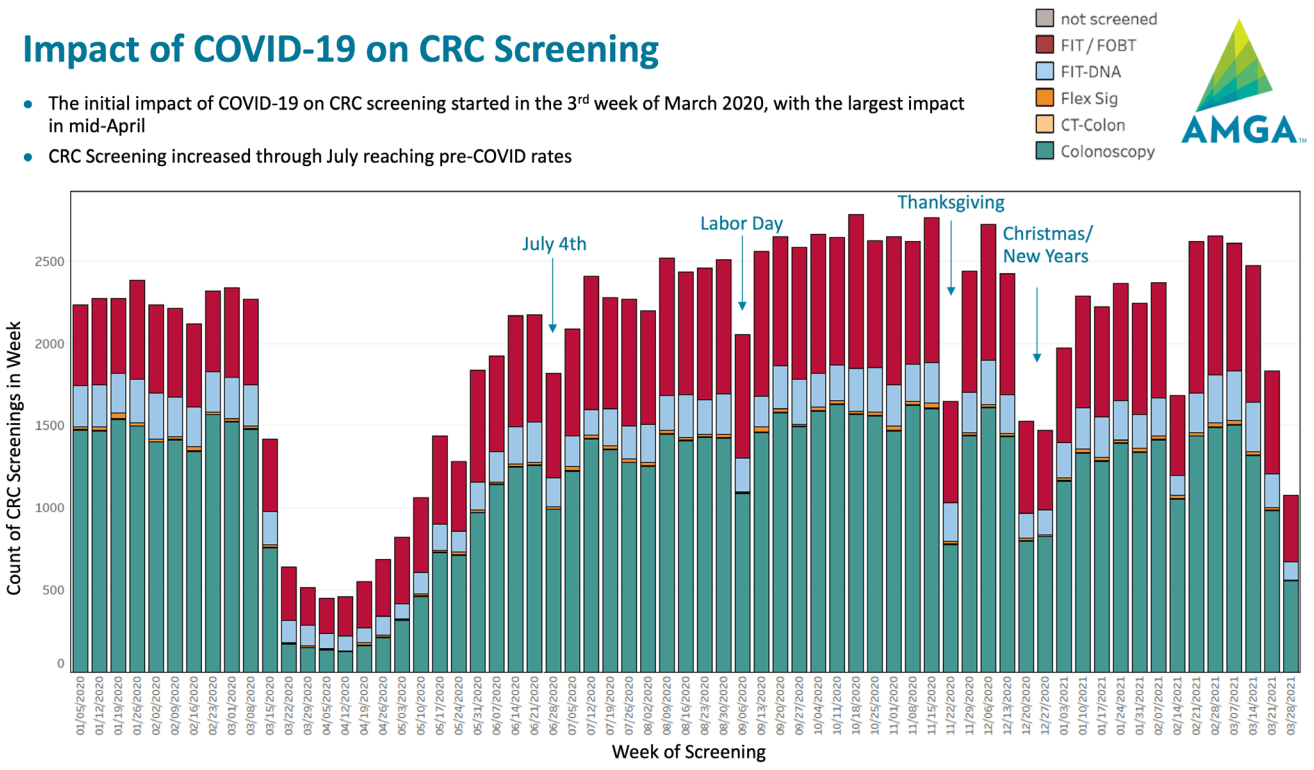
One key highlight: While variations emerged across screening types, between organizations, and across sites, screening rates overall improved from 2019 to 2021.

The average increase was 7%, with a 2% increase from 2020 to 2021. Some of this improvement can be attributed to education, social media, and competition among sites, Tallam said.

Colorectal Cancer Screening

COVID-19 had an undeniable and multifaceted impact on screening, decreasing as much as 80% in April 2020 compared to pre-pandemic volumes, followed by a quick recovery. By July 2020, screening was above pre-pandemic volumes, particularly for stool-based testing, due to lockdown mandates and social distancing protocols, as well as convenience, cost, and the ability to boost screening rates.

Figure 3: Improvement in CRC Screening Rates 2019-2021



Yet colonoscopy rates after a positive FIT remain an area for improvement. Effective follow-up requires outreach, gastrointestinal (GI) referrals, and the procedure itself, with delays greater than 10 months of the initial test associated with increased risk of any and advanced stage CRC. Several factors may affect the likelihood of follow-up after a positive Cologuard test or FIT.

Stempniewicz pointed out differences in follow-up rates by insurance type, with commercial and Medicare reporting higher follow-up rates than Medicaid.

"A theme that was persistent throughout was the benefits of analyzing and stratifying your own data. You can identify high-performance sites with lessons to share, areas for improvement, and hidden areas of opportunity."

— Nikita Stempniewicz, M.S., Director, Research and Analytics, AMGA

AMGA data also revealed substantial variation in screening rates within organizations, across sites of care, and by race and ethnicity. Asian and Hispanic groups had lower screening rates and colonoscopy use, for example.

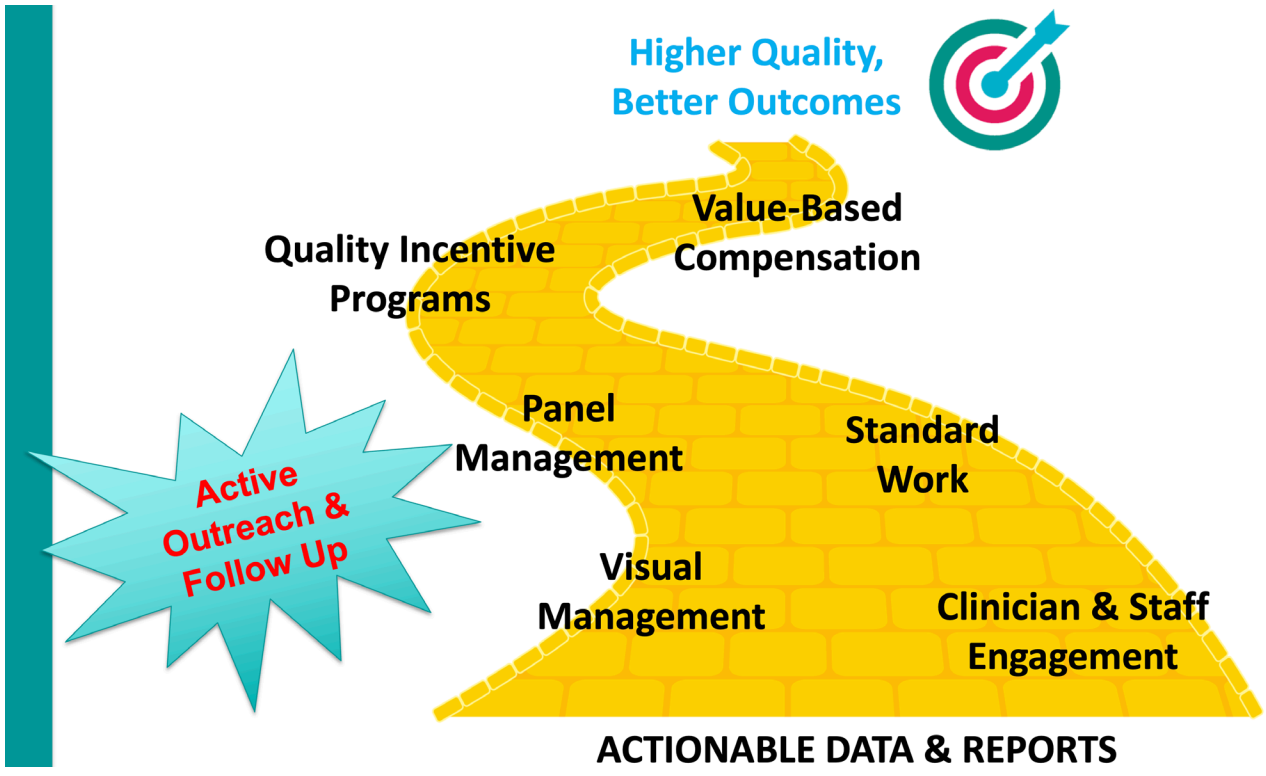
All of this underscores the importance of education, benchmarking, and documentation, Stempniewicz and Tallam said.

CRC QuIC National Advisor Panel

Frank Colangelo, M.D., M.S.-HQS, FACP, *Allegheny Health Network and Premier Medical Associates;* **Megan Romine, D.O., M.H.A., FACP**, *UnityPoint Health;* **Annie Sy, Pharm.D., M.H.S.A.**, *Sutter Valley Medical Foundation*

In this session, three CRC QuIC advisors shared highlights from their own organization's work in the top three ranked problems, including lack of patient awareness and education about CRC, screening, and prevention; disparities in care; and lack of a clinical workflow/pathway for CRC screening. Annie Sy from Sutter Valley Medical Foundation talked about how the pandemic highlighted opportunities for closing gaps in care, specifically among higher-risk populations such as older patients, African Americans, and Medicaid patients. By leveraging the vast amounts of data in EMRs and pulling actionable reports, Sutter has been able to identify the most vulnerable patients, funnel resources toward them, and bring them in for screening.

Figure 4: The Road to Higher Quality and Better Outcomes



Yet more work remains, Sy said. Improvement will depend on standard activities for both outreach and "inreach" and more data—specifically performance data on these high-risk populations to engage providers and staff. "Everyone needs to have some skin in the game for improving performance and ensuring that all our patients are getting the recommended screenings," she said.

Premier Medical Associates has increased its CRC screening rates from 57% to above 80%, and Frank Colangelo talked about how the organization got there. "One of the biggest challenges was patients saying: 'I don't have colorectal cancer in my family, I'm not at risk,'" he said. "We're educating people that everyone ages 50-74 is at risk."

Premier employs a variety of tactics to do so: Brochures on site, posters in the exam rooms, and proactive discussions during annual check-ups and other visits. Providers also learn about the importance of offering hesitant patients a testing choice beyond a colonoscopy.

Patient hesitancy has been top of mind at UnityPoint as well. "The first step is to engage patients and ask what their concerns and barriers are. Is it finding transportation? Is it fear of anesthesia? We don't know unless we have those conversations," said Megan Romine.

To address these types of barriers—for colorectal cancer and other conditions—UnityPoint has launched a system-wide initiative focused on the social determinants of health. The goal is to screen patients for healthcare barriers at all sites, from the ER to the hospital, and then match the patient with an appropriate community resource to help overcome the barrier. For CRC screenings, lack of transportation was a significant barrier.

Romine noted that her team's work has been energized by UnityPoint's partnership with AMGA and participation in the CRC QuIC and other collaboratives. She shared other tactics UnityPoint has used to improve screening rates: Working with payers on member engagement and coverage for follow-up screenings, working with specialists to get their buy-in for screening, and using tactics like webinars to deliver education on screening throughout the UnityPoint network.

Colorectal Cancer Screening: Myth Busters – Patient and Provider Alignment

Allison Rosen, *CRC Survivor and Project Director, The University of Texas Health Science Center at Houston, and* **Daniel Duncanson, M.D.**, *Primary Care, SIMEDHealth*

At age 32, with an active life and a busy career in a research lab, CRC was the last thing from Allison Rosen's mind. Then fatigue, coupled with a history of Crohn's disease, led her to meet with her Gastroenterologist (GI). Her colonoscopy came back positive.

From there, her concerns were many and extended beyond immediate fears about the disease. Would radiation and chemotherapy affect her fertility? Would she be able to take off work for treatments and still keep her job, which she depended on for health insurance? And would she be able to find a doctor who truly listened to her concerns and treated her as more than just a number?

Her fight against CRC and subsequent journey back to health was grueling, and the experience changed Rosen's life in more ways than one. As she struggled to multitask in the lab due to side effects of treatment, she found herself telling everyone she knew about the lifesaving benefits of screening for colon cancer. Her passion for advocacy grew, eventually leading to her current Project Director position at UTHealth. In this position, she can also use her knowledge as a patient advocate to benefit the patient journey in revealing barriers and improving patient-provider communications.

Based on her personal and professional experiences, Rosen shared her advice for clinicians and health systems:

- Use multiple touchpoints to educate, from posters in the exam rooms to pocket cards that guide providers through difficult conversations.
- "Meet patients where they're at, show empathy, and keep talking. There might be a reason they're not getting that colonoscopy. Maybe they don't have a companion to go with them, they don't understand the prep, or they don't want to take a day off work."
- "Create a collection of patient stories that don't look like the typical colorectal cancer patient, because there isn't a typical colorectal cancer patient. Make outreach entertaining and fun and educational."

Daniel Duncanson at SIMEDHealth echoed the importance of making outreach efforts entertaining and fun. He described competitions to improve screening rates, engaging teams named the Colon Crusaders and Poop-erazies, and a four-foot trophy that now serves as a lobby conversation piece.

It's all part of a multipronged, multifaceted initiative at SIMEDHealth to make colorectal cancer screening more relatable for patients and part of the overall culture for providers: Educating doctors, working with GIs, incorporating messages in the patient portal and EHR, and more.

"The repetitiveness of the efforts, staff knowing how to respond to questions when they get phone calls—that's the importance of having a culture around screening," Duncanson said.

CRC Screening Secrets to Success Panel

Diane George, *D.O., Family Medicine, Henry Ford Health System, and* **Scott Barlow, M.B.A.**, *CEO, Revere Health*

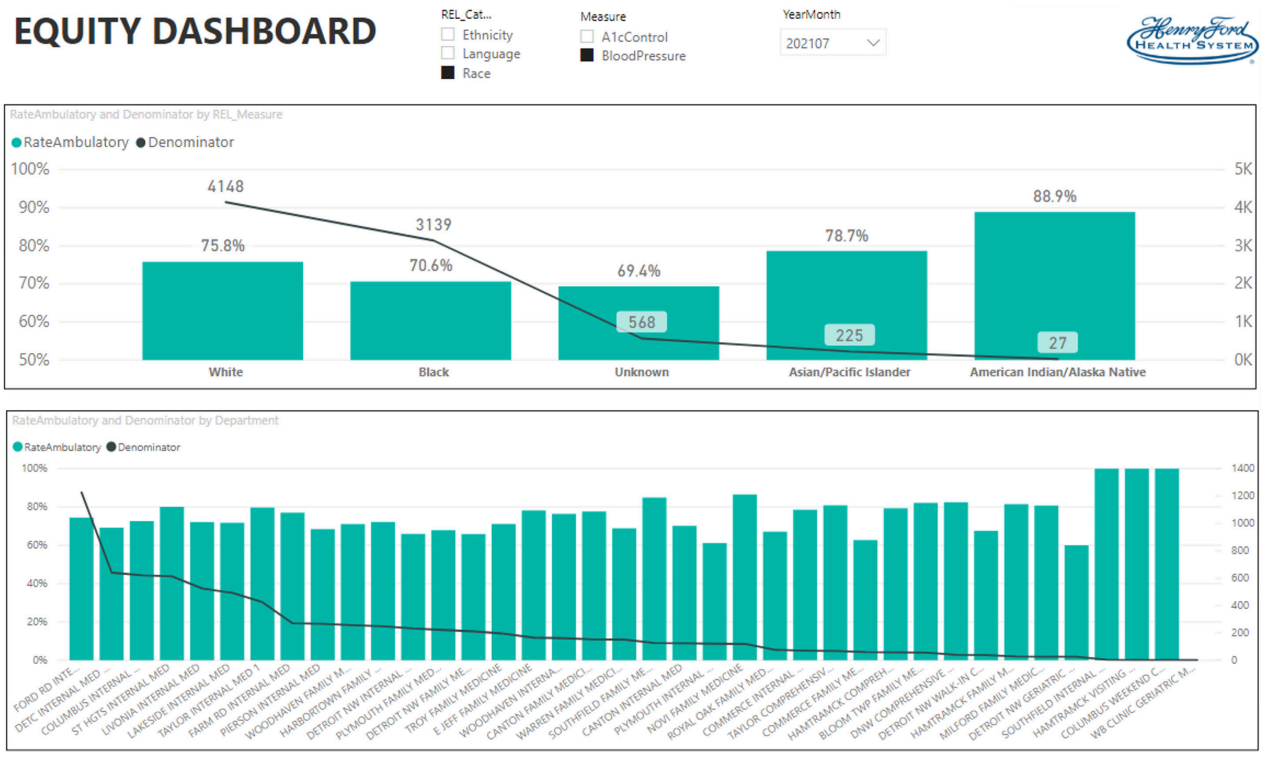
For CRC screening and in health care in general, one powerful way to improve results is through data. Diane George and Scott Barlow shared examples from their organizations.

With open-access colonoscopies and no need for GI referrals in certain cases, Henry Ford had good scores for CRC screening rates. But the organization had hit a plateau in its efforts, George said.

Efforts to expand standing orders for ordering tests to medical assistants generated pushback from physicians, who feared the use of FITs rather than colonoscopies for higher-risk patients. The addition of a SmartSet in Epic enabled nurses to gauge patient risk. Still, some clinics were performing better than others.

The next step was to create an equity dashboard, a foundational step in more targeted outreach, George said. For this dashboard, Henry Ford looked at five key metrics, with an eye for the findings that stood out and merited further exploration (see Figure 5). How did screening rates for minorities compare to those of White populations? Were there significant differences across age and gender? Were there lessons to be learned from the organization's work with high blood pressure or diabetes?

Figure 5: Henry Ford's Equity Dashboard for Key Quality Metrics



Henry Ford recommends assessing the data findings and identifying successes. It is also beneficial to ask the population what they are experiencing and adapt to those needs.

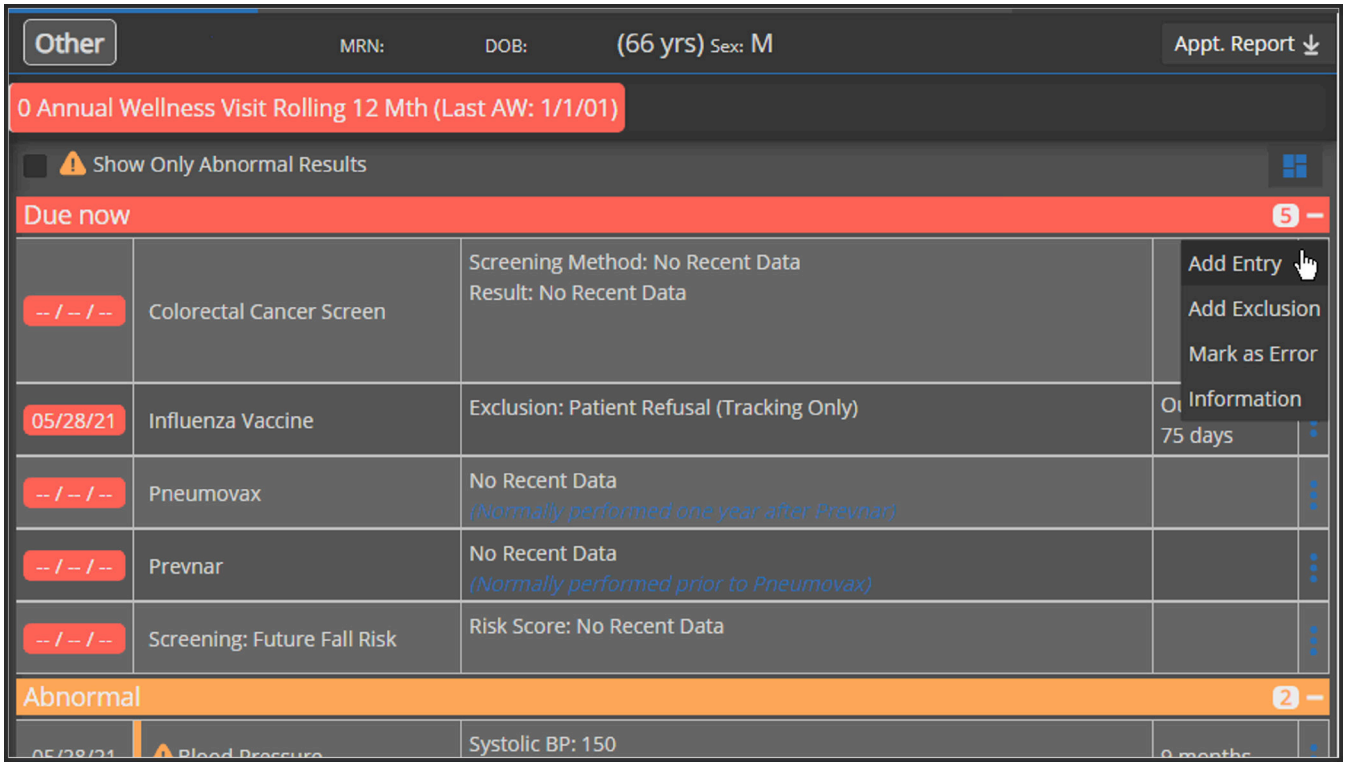
Revere Health uses data to improve the delivery of its CRC screening services, Barlow said. It's a whole-system, patient-centric approach, aimed toward aligning incentives and sharing successes.

Through a single screen of information and intuitive features like walk-down menus, staff see what activities are needed, such as scheduling and ordering tests, and take the right steps to make them happen (see Figure 6).

Every time an interaction occurs, the work receives a score, feeding into quarterly incentives tied to this reporting. This focuses all relevant staff—from care teams to the billing department, receptionists to managers—on what's needed to improve screening rates and help patients.

"Every part of the delivery system is required to take steps," Barlow said. "But people are busy, and this is extra work, so it's also important to find those champions and nuggets that can be shared across the system."

Figure 6: Revere Health Annual Wellness Visit Screenshot



Breakout Sessions

In multiple concurrent conversations, CRC QuIC participants discussed specific aspects of CRC screening that they will focus on implementing in the coming months: Clinical workflows and pathways, patient awareness and education, disparities in care, ways to identify patients in need of screening, and tools for clinical decision support.

Each group shared their challenges and successes from specific interventions, as well as key takeaways and lessons learned from the overall event.

Sutter Medical Foundation and Lehigh Valley Physician Group examine clinical workflows and pathways

While some regions at Sutter Medical Foundation have achieved 80% screening, others have not. To close these gaps, Lori Lange talked about a need to make outreach, follow-up, and follow-through more consistent across its practices and locations, from ensuring a test is ordered when a patient is there to making sure the patient actually gets the screening done. “This is an opportunity to create a standard approach that works, with data behind it,” Lange said.

One part of the solution has leveraged data: Patient lists for outreach and ticklers for appointment reminders, as well as alerts when patients don’t complete at-home tests. Yet another tactic involves a more human part of the clinical workflow.

Meanwhile, Lehigh Valley Physician Group has been challenged to expand screening efforts amid staff turnover, competing demands, and budget limitations, according to Brian Stello.

There is no well-developed system for tracking positive tests centrally at this time. Meanwhile, some GIs and other stakeholders still resist Lehigh Valley Physician Group's shift to direct-order colonoscopies, despite the potential screening benefits.

With more robust clinical pathways, he said, his teams could have more robust dashboards for measures like these and, therefore, the data to generate buy-in for new practices. In the meantime, other low-tech fixes have helped Lehigh Valley Physician Group screening teams do more with less.

"If you start writing a return date on the kit, it supports the completion," Stello observed. "It's a simple thing to do."

INTEGRIS Medical Group, Privia Medical Group - North Texas, and Utica Park Clinic share patient outreach and education challenges and tactics

INTEGRIS Medical Group has been implementing some targeted approaches for patient awareness but still needed to centralize these efforts, to ensure education at the point of care and in offices and to expand the subject matter relayed to patients. Specifically, said Pat Dale, "Patients were really not informed about the different choices across all patient encounters and outreach."

One obstacle has been scale. INTEGRIS Medical Group has been looking into options for text messaging and mass outreach by telephone. However, the organization has not yet adopted bulk messaging capabilities—and this holds education efforts back.

"My group is supporting the clinics with dedicated outreach through phone calls," said Tonia Garner. "We can give them their options, identify barriers, and work with them on those barriers. But you can only reach so many people one at a time."

Privia Medical Group - North Texas has been scaling its outreach with bulk email campaigns—and is open to additional ideas for organization-wide efforts. "We did an email blast to all patients within the age range," said Amy Atkins. "I'd really love to hear what else we can do from central office to take this off the plates of the clinics."

Participants shared tactics for dispensing knowledge, from one-page education sheets to staff huddles, to FIT kits that come with instructions. They also talked about supporting these activities with a shift in perspective: Revisiting language (calling colonoscopies "colon cancer screening," for example) and convincing providers and patients alike to consider stool testing products like FIT and Cologuard as a screening option. Participants shared that spreading awareness on types of screening, other than colonoscopy, is essential to meeting patients where they are. The message shared that resonated the most with clinicians was "the best test is the test that gets done."

Stacie Scott with Utica Park Clinic advised that organizations work with payers to add Cologuard into coverage contracts. In patient and provider conversations, use scripting and repetition to emphasize the importance of screening. "I think if there was a little more of a push for physicians to educate, or even some scenarios, patients would understand just how important this is," Scott said.

Colorectal Cancer Screening

Carle Physician Group, Geisinger, Intermountain Healthcare, and Prevea Health discuss disparities in care

Particularly since the onset of the COVID-19 pandemic, understaffed teams have faced myriad obstacles in testing for CRC: Screening backlogs, language barriers, low patient trust, and more.

One aspect of the solution involves addressing disparities in care, including social determinants of health. Participants discussed where they are in this journey, from cutting through the "noise" to knowing where to focus first to overcome patient resistance and administrative bottlenecks.

"I think we could make a big difference by breaking things down a little bit, looking at where the gaps are and not treating everybody as one," said Sondra Hillberg with Prevea Health.

"It hasn't been a standard to collect things like social determinants of health in our electronic medical record, but can see how this would be beneficial and could give us accurate data to act on to help us improve the health of our patients," said Julia Langer.

"Social determinants of health is something we just added into our Epic medical record," said Heather Mosley at Geisinger. That being said: "The queue of CRC screenings has increased drastically this quarter. We have implemented a process to review our patients and the necessity of having a colonoscopy vs. using Cologuard,"she said. One of several initiatives to address the backlog included working with Exact Sciences as a resource to provide their average-risk patients with Cologuard kits as a first step before colonoscopy.

"We're trying to make this an automated process by providing screening at different encounter types," said Amy Luzier-Barrett with Geisinger.

Another participant also shared administrative challenges, specifically with connection of workflow issues, referral process, and patient follow-up if they don't follow through with completing the screening.

Nate Merriman with Intermountain Healthcare noted screening hesitancy with patients in rural areas, with thoughts as to possible reasons.

"We're partnering with our rural health teams to connect with patients about what's holding them back from getting their screening," he said. "By working together with our rural care teammates, we have realized the barriers to colon cancer screening potentially very different than the barriers in our more urban communities. These are very small communities, and we need to make sure we are listening to their concerns and designing care plans in partnership with our rural care teams and their patients."

"We have been seeing a lack of trust and confidence in health care," said Laura Nickrent with Carle Physician Group. "Even though the providers are suggesting this, they're not following through as much as they would have five or six years ago."

Could leadership at the top or dedicated focus on social issues and disparities help build trust and close gaps? Like Prevea, another participant also has a new leader in a diversity and inclusion role. They would be interested in including social determinants of health in their practice.

Screening and identification of patients and clinical decision support tools with Kelsey-Seybold Clinic and Summit Medical Group

With many aspects of colorectal cancer screening, the devil is in the details—particularly when those details involve reimbursement.

This was the case at Kelsey-Seybold Clinic, according to Leon Jerrels. "We send secure portal messages for patients to self-request a test." While some vendors will only charge healthcare providers for completed tests, "out here, the lab will charge us for the text kit if the patient gets the test and doesn't send it back," he said.

Participants discussed ways to increase test completion. They reiterated the value of calling a colonoscopy a "colon cancer screening" and building relationships with GIs, particularly to get buy-in for using colonoscopies only as a follow-up to a FIT.

In the area of awareness, they suggested increasing outreach beyond a sole notification letter and training physicians on how to educate patients, particularly so conversations about screening can start earlier (e.g., at age 42-43) during routine physicals.

"We need to begin educating patients of the importance on colorectal screening, *the why* behind it, years before screenings are recommended," said Wendy Ferrell-Smith with Summit Medical Group.

Yet organizations may not be able to lower the screening age in an EMR or document family history in a standardized fashion, enabling the identification of at-risk patients. Organizations may lack a centralized system for following up on positive FITs, and GIs may be overloaded.

Yet the biggest challenge involves people: Getting physicians to have deep conversations with patients and overcoming perceptions like "shared decision-making takes too long" or "isn't the FIT enough?"

"It's about making sure everyone has a shared vision, a shared goal, a shared understanding," said Jennifer MacDonald with Summit Medical Group.

Next Steps

AMGA Foundation's Danielle Casanova concluded the event with next steps and the road ahead:

- Submitting a goal and plan for a tailored intervention (by October 29, 2021)
- Submitting full quality improvement documentation (by February 7, 2022)
- Attending the April 2022 two-day, virtual/in-person hands-on workshop , with an agenda informed by the above submissions

"We are here for you and to support your needs and efforts over the next several months," she said.

AMGA CRC QuIC Team

John W. Kennedy, M.D., President, AMGA Foundation and Chief Medical Officer, AMGA

Danielle Casanova, M.B.A., Senior Director, Population Health Initiatives

Earlean Chambers, RN, M.S., CPHQ, Director, Clinical and Quality, Population Health Initiatives

Erin Leaver-Schmidt, M.P.H., Senior Program Manager, Population Health Initiatives

Cameron Meade, Coordinator, Population Health Initiatives

Elizabeth Ciemins, Ph.D., M.P.H., M.A., Vice President, Research and Analytics

Nikita Stempniewicz, M.S. (C), Director, Research and Analytics

AMGA™
Advancing High Performance Health

One Prince Street
Alexandria, VA 22314-3318

amga.org/foundation