May 15th, 2017
8:00AM – 4:30 PM

Increasing Colorectal Cancer Screening in New York State

WORKSHOP 1: UTILIZING YOUR EMR FOR PRACTICE IMPROVEMENT

Utilizing Your EMR for Practice Improvement

Presented by:
Linda Franke
Emily Mader

Getting Started: Why Do Practices Need Data?

- Quality performance evaluations
  - Value-based payment agreements with insurance payers
- NCQA requirements for PCMH certification
- Managing population health

Getting Started: How Do Practices Use Data?

- Gap lists
  - Identifying patients who need targeted services
- Pre-visit planning
- Scheduling
  - Identify patients at risk of no-show

<u>All of these specific activities are driven by one thing….</u>

REGISTRIES

- Registries are the driver of data use within a practice

- What is a registry?
  - A list of people identified by a set of criteria or shared characteristics
  - Follow evidence-based guidelines and standards

  - Example: Colorectal cancer screening registry
    - Age: 50-75
    - Sex: Male and Female
    - History: No personal history of colorectal cancer or total colectomy

REGISTRIES

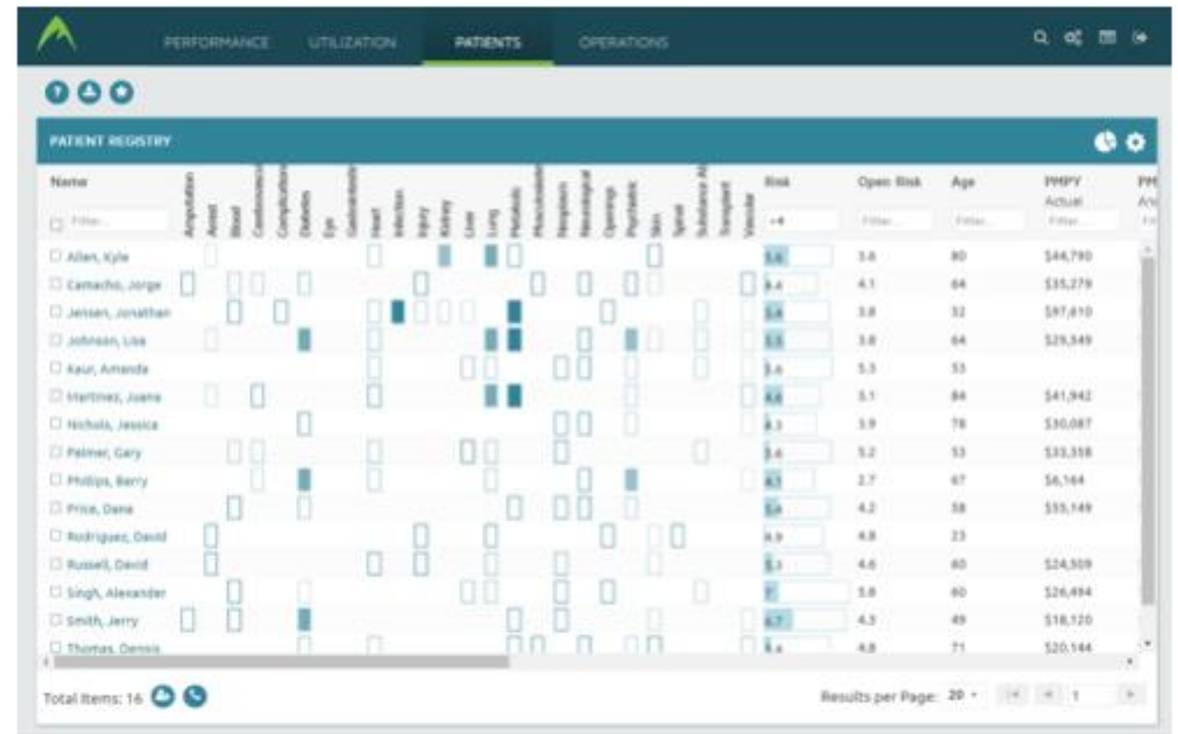
- Registries can be developed for a wide variety of targeted patient groups
  - Cancer screening
  - Immunizations
  - Insurance groups
  - No-show/high cancellation patients
  - Condition-specific groups (diabetes, chronic kidney disease, depression)
  - Payer-assigned metrics

- Registries also inform the creation of dashboards
  - Allow for a high-level view of how the practice is performing across several targeted measures or patient groups

REGISTRIES: Examples

LEADERBOARDS AND TRENDS

IDENTIFY OPPORTUNITIES



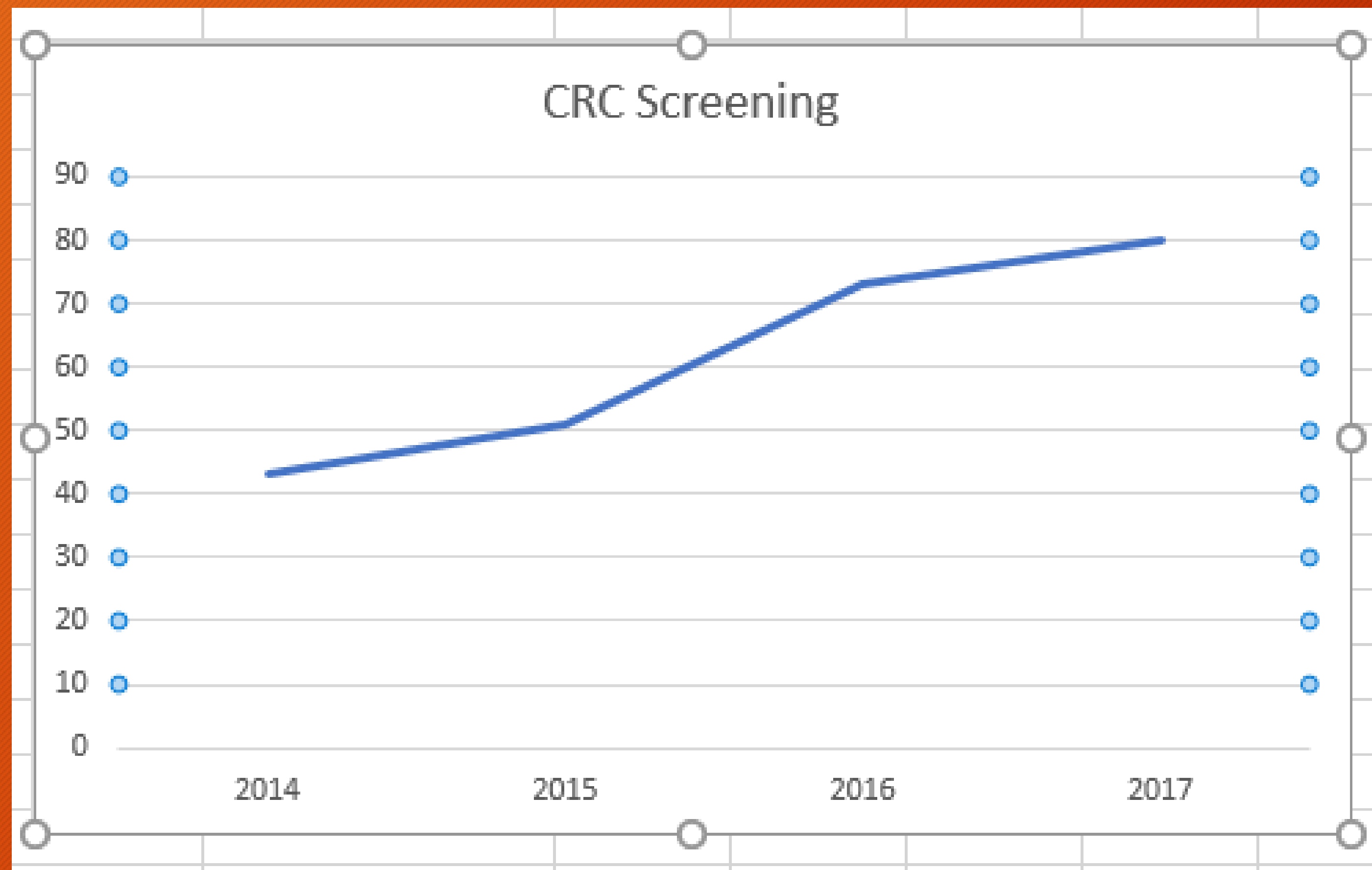
Driving Change

- How can practices effect change through registry-based data?
- Dashboards based upon defined patient registries inform practices of performance gaps
- Practices can drill into targeted gaps to identify opportunities for change
  - Develop rapid-cycle improvement plans (e.g., PDSA cycle)
  - Small adjustments to workflow can be tested and expanded

Driving Change: Practice Example

- A rural practice, about 10,000 patients
- First we ran a registry and tried TalkSoft for patient reminders by phone as well as increased patient education
- Next we re-ran the registry and looked for duplicates, then made personal calls to the patients
- Finally, we ran another registry and did an in-depth chart review
  - Family charts/worker’s comp
  - Resulted in much better data!

Results!



Importance of the Feedback Loop

Registry-driven data can be a powerful tool for improvement

BUT…..

it has to be transparent to really be effective

Importance of the Feedback Loop

- Dissemination of registry data
  - Format
    - Dashboard views
    - Patient gap list
    - Calculated performance rates
  - Audience
    - Care team providers (physicians, nurses, behavioral health, dieticians, etc.)
    - Administrative staff (practice manager, referral team, scheduling, etc.)
  - Granularity
    - Overall practice level
    - Physician level
    - Care team level

Important Considerations

- Developing registries takes time! And effort! And software!
- Resources do exist to help
  - Vendors
  - Health system IT
  - Grants
  - Students
  - Practice learning collaboratives
- Every practice has a different scenario of what is available, so explore your options!

Group Feedback

- What is your experience with utilizing data and different components of EMRs?
- How do you integrate a registry with clinical care?
- Who have you engaged with in your practice or outside of your practice to operate your EMR, patient registry, etc.?

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WORKSHOP 2: COORDINATING PRACTICE EFFORTS

COORDINATING PRACTICE EFFORTS

Make a plan, Inspire the team, Work together

Presenters

- Gary Noronha MD, FACP
  - Internal Medicine University of Rochester Medical Center
  - Assistant Professor Medicine and Center for Community Health
  - Co-Director Greater Rochester Practice Based Research Network (GRPBRN)
  - Director UNYTE Translational Research Network
- Victoria Hall BSN RN MPH
  - Practice Enhancement Associate
  - Primary Care Research Institute
  - Department of Family Medicine
  - University at Buffalo

- No relevant disclosures

Agenda

- Defining Workflow
- Make a Plan
  - Setting and Aligning Goals
  - Developing and Implementing New Workflows
- Inspire the Team
  - Improving Buy In
- Work Together
  - Workflow Examples
  - Team Based Care Principles
  - Examples of Successful
- Group discussion

Workflows: Define, Develop, Implement

- What is Workflow?
- How do you develop new Workflows?
- What makes staff buy in more likely to happen?

What is workflow?

- Defined as a series of steps, frequently performed by different staff members and often dependent on related workflows, that accomplishes a particular task.

- Workflows represent how work actually gets done, not the protocols that have been established to do the work.

http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod5.html

What does Workflow have to do with Screening?

- The right workflow helps make screening happen!
- Targets provider/practice attention to the right patients (Previsit)
- Primes the patient with helpful information (Visit)
- Provides reminders / follow ups for patients and providers (Post Visit)
- Ensures information enters the chart clearly so it’s easier to track and repeat as indicated (Post Screen)

Make a Plan

Setting Goals: Deciding "what" before "how"

- What do you want to achieve
  - Is it measurable/ realistic / well defined?
  - In what time frame?
  - Whose definitions for eligibility will you use?
- Are there other incentives/needs that align? (PCMH, Meaningful Use, DSRIP)
  - How can you leverage one activity to support another?

- Our experience:
  - Differing definitions (who needs screening, what interval) can have a big impact on numbers
  - The more a QI program aligns with existing incentives the easier it is to get staff buy in.
  - The more programs align with each other the more resources that can be brought to bear

- Remember to define and articulate "why" as well as "what" and "how"

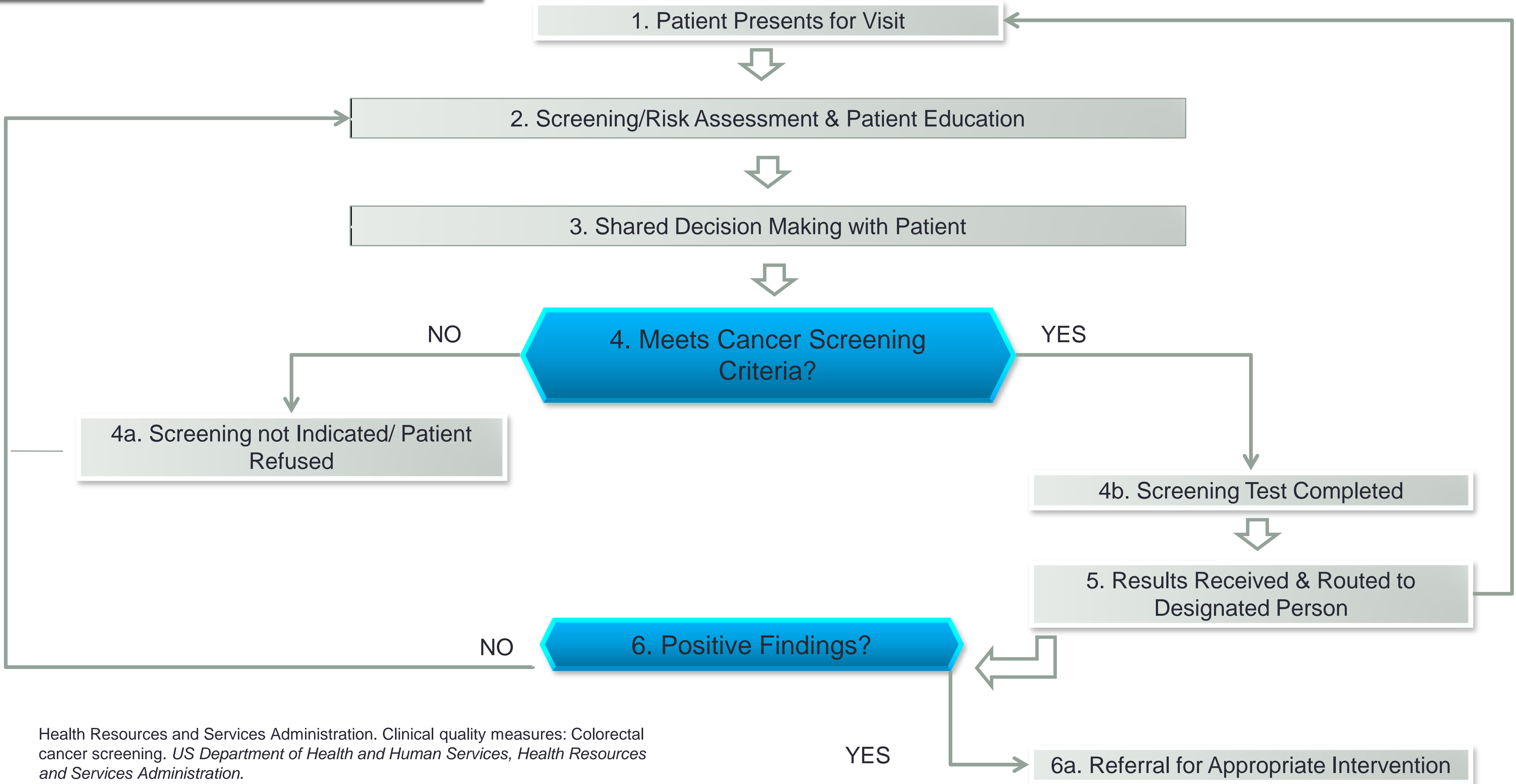
Developing Workflow Protocols

- Identify a particular process that needs improvement
- Assemble a group of staff members that influence that process
- Map out how the process is currently done
- Identify problem areas/gaps within the current process
- Brainstorm solutions/workarounds
- Incorporate solutions into current process
- Assign responsibilities
- Test out new workflow

Adopting Workflow Protocols into Policy

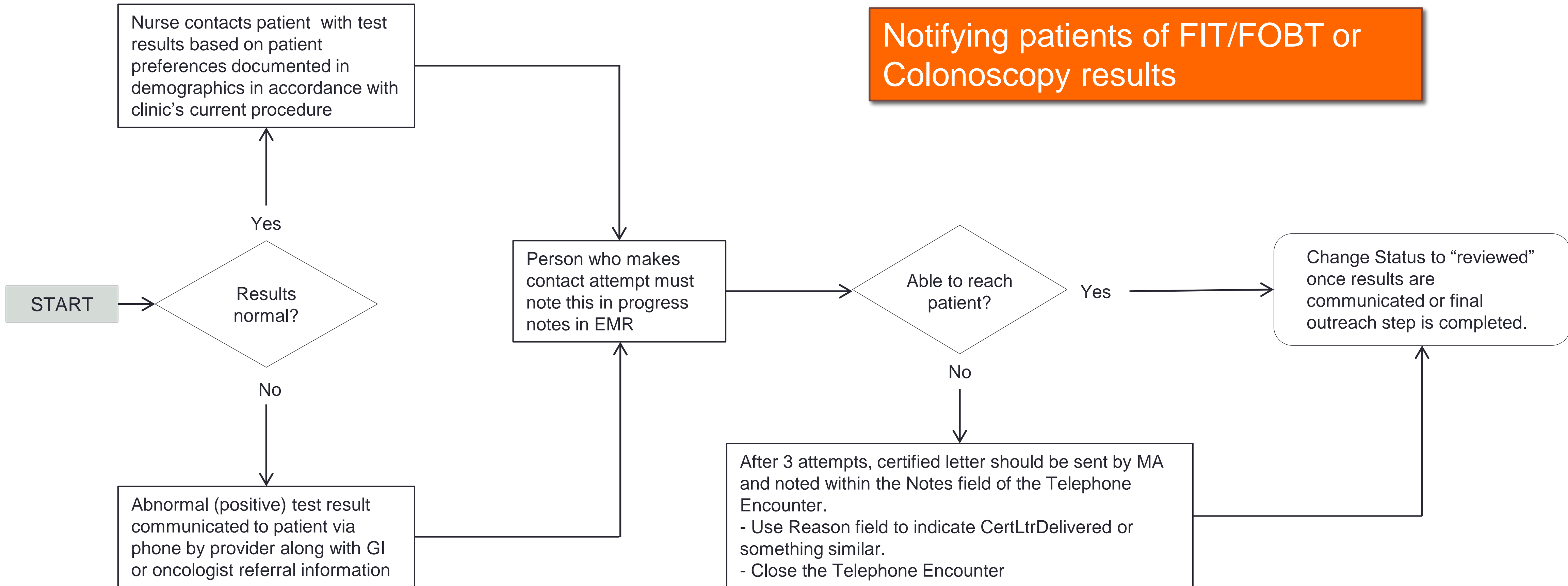
- Standardize process so it is done consistently
- Have an easily accessible, written copy of process
- Ensure all staff members are educated about process and team members' responsibilities
- Incorporate responsibilities into job description
- Simplify process as much as possible
  - minimize number of steps and number of people involved
- Review/audit process on a recurring basis
  - Helps maintain consistency
  - Helps identify further opportunities for improvement

Workflow for Cancer Screening –



Health Resources and Services Administration. Clinical quality measures: Colorectal cancer screening. *US Department of Health and Human Services, Health Resources and Services Administration*. http://www.hrsa.gov/quality/toolbox/measures/colorectalcancer/index.html

Workflow after Screening is Completed



Adapted from: http://hcnny.org/wp-content/uploads/2016/04/CRC-Screening-eCW-Best-Practices-Guide-HCNNY-112015-1.pdf

Inspire the Team

Creating Buy in for Workflow Changes

- Have staff work to develop the workflow
- Make sure projects align with existing priorities (e.g., PCMH, MU, DSRIP)
- Make performance data available to everyone (at practice level at least)
- Make the “Why” clear. Identify de-identified patient stories that can create motivation.
- Create workflows that work for multiple issues at once
- Be sure staff are trained on the “what” “why” and “how”
- Identify a Project Champion

Identifying a Project Champion

- Has authority/influence to drive project forward
- Clearly informs practice staff about purpose and scope of work
- Has time dedicated to work on project
- Enthusiastically promotes project and engages practice staff
- Gathers needed resources

- J Am Board Fam Med. 2012 Sep-Oct; 25(5): 676–685.
- doi: 10.3122/jabfm.2012.05.110281

Team Based Care Improves Buy In

- Shared responsibility for the patient – not just the provider's job
- Delegation of tasks / coordination of effort
- Use of protocols to move more work away from the provider
- Everyone works at the top of their licensure
- Effective regular inter-professional communication

1. HTTP://WWW.IHI.ORG/COMMUNITIES/BLOGS/_LAYOUTS/IHI/COMMUNITY/BLOG/ITEMVIEW.ASPX?LIST=0F316DB6-7F8A-430F-A63A-ED7602D1366A&ID=29
2. HTTP://WWW.IHI.ORG/RESOURCES/PAGES/CHANGES/OPTIMIZETHECARETEAM.ASPX

Work Together

Successful Workflows to Support Screening

- Pre-visit
- During Visit
  - nursing/provider/check out
- Post Visit before screening occurs
- Post Screening

Pre Visit Identify patients in need of screening

- Pre-Visit Planning
- Registries
- Insurance Lists

Pre-Visit Planning

- Ensure all staff know patient is due for screening
- Allows team based approach so that patient may receive information about screening prior to seeing physicians
  - Distribute brochures on screening needs
- Ensure needed materials are available
  - Having FIT kit in room for patients due
- Allows potential bundling of appointment
  - Have PAP while at routine appointment
  - Have mammogram immediately following appointment (when available on site)
  - Distribute FIT kit at appointment

During Visit: Remind, Educate, Support

- Chart Reminders (paper/electronic)
- Point of Care Decision support
- Patient education on options
  - Written, verbal, video – who provides
- Reinforcement of plan from multiple levels
- Assistance in scheduling

Examples of Tools to Support Screening

Health Maintenance

Name: ____________________

HIV Screening

Due______ UTD _______ NA _______

Mammogram

Due __________ Place ____________________

DEXA

Due __________ Place ____________________

Colonoscopy

Due __________ Doctor ____________________

Diabetic Exams

Foot Exam _____ Due _____ UTD

Lipids _____ Due _____ Ordered _____ UTD

HGA1C _____ Due _____ Ordered _____ UTD

Micro albumin _____ Due _____ Ordered _____ UTD

Diabetic Eye Exam

__________ Due Date _______ UTD

_______ None

Health Maintenance Report
5/19/2016 Appointment — MRN:

Health Maintenance

	Date Due	Completion Dates
BREAST CANCER SCREENING	10/7/2014	10/7/2013, 9/27/2012
CERVICAL CANCER SCREEN PAP EVERY 1 YEAR	4/14/2015	4/14/2014, 3/14/2013
IMM-INFLUENZA (1)	9/1/2016	10/15/2015, 9/4/2014, 9/25/201 10/2/2012
COLON CANCER SCREENING 1 YEAR COLONOSCOPY	11/23/2016	11/23/2015, 10/27/2010

Health Maintenance Modifiers

Cervical Cancer Screening every 1 year
Colonoscopy - every 1 year
Hepatitis c screening
Mammogram every 1 year

Health Maintenance

Name: ____________________

Mammogram

Due __________ Place ____________________

DEXA

Due __________ Place ____________________

Colonoscopy

Due __________ Doctor ____________________

Post Visit: Trust but Verify

- Tracking to ensure screening is done
- Targeted reminders
- Trouble shoot road blocks for patients (insurance issues, transportation)

Post Screening: Close the loop

- EMR data entry – workflows /staff responsibilities
- How do you find out where your patients receive care outside your office?
- How do you communicate with outside providers?
- What's the next screening interval (i.e colonoscopies with polyps)?
- Abnormal results who/ how are they handled?
- Patient feedback – an opportunity for education.

Roles the staff may play in improving screening rates

- Identify patients / flag charts to indicate patients needing screening
- Outreach to patients lost to follow up or provide reminders
- Distribute brochures and information to patients due
- Begin the conversation, allow patient to ask questions
- Serve as the “confidant” for patients with difficult questions about screening
- Describe the process of screening in more detail
  - What the procedure is like
  - What preparation is like
  - Time, location, etc
- Reinforce and reiterate recommendations made during the visit
- Trouble shoot road blocks for screening (transportation, insurance coverage)

Key Points

- Engage Staff
  - Align Programs and Workflows with existing projects
  - Talk about WHY as well as What and How
  - Find a Project Champion
- Solutions can be high and low tech
- Team Based Care is Essential
  - Identify who is responsible for each step in the process
  - Doesn’t just have to be the doctors and the nurses

Discussion Questions

- What have been your experiences with team-based approaches to identifying and tracking patients needing screenings in your practice?
  - What are some of the common and challenging barriers?
  - Any particular successes or failures?
  - Let’s brainstorm some solutions to these barriers
- How have you overcome difficulties communicating with outside providers to close the screening loop on your patient?
- What strategies have you used to have successful conversations on screening?

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WORKSHOP 3: PATIENT OUTREACH AND ENGAGEMENT

Presented by:

Carlos Swanger, MD
University of Rochester Medical Center

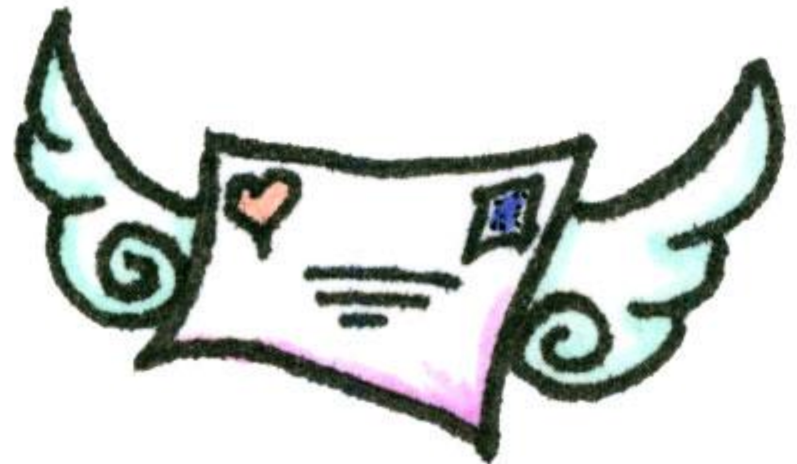
Jason Coleman
American Cancer Society

Patient Concern

- Cost
- Discomfort or fear
- Comprehension
- Difficulty navigating the system

Evidence-based Patient Outreach

- Small media
- Reminders
- One-on-one education
- Reducing structural barriers



The role of Care Coordinators

- Effective communication
- Interface with clinical team
- Data exchange
- PCMH status; Medicaid Managed Care

Discussion

- What have you found to be most effective at engaging patients to understand and complete screening?
- What are some of the most common and influential barriers?
- Who else have you engaged in your practice to discuss the importance of screening with a patient?

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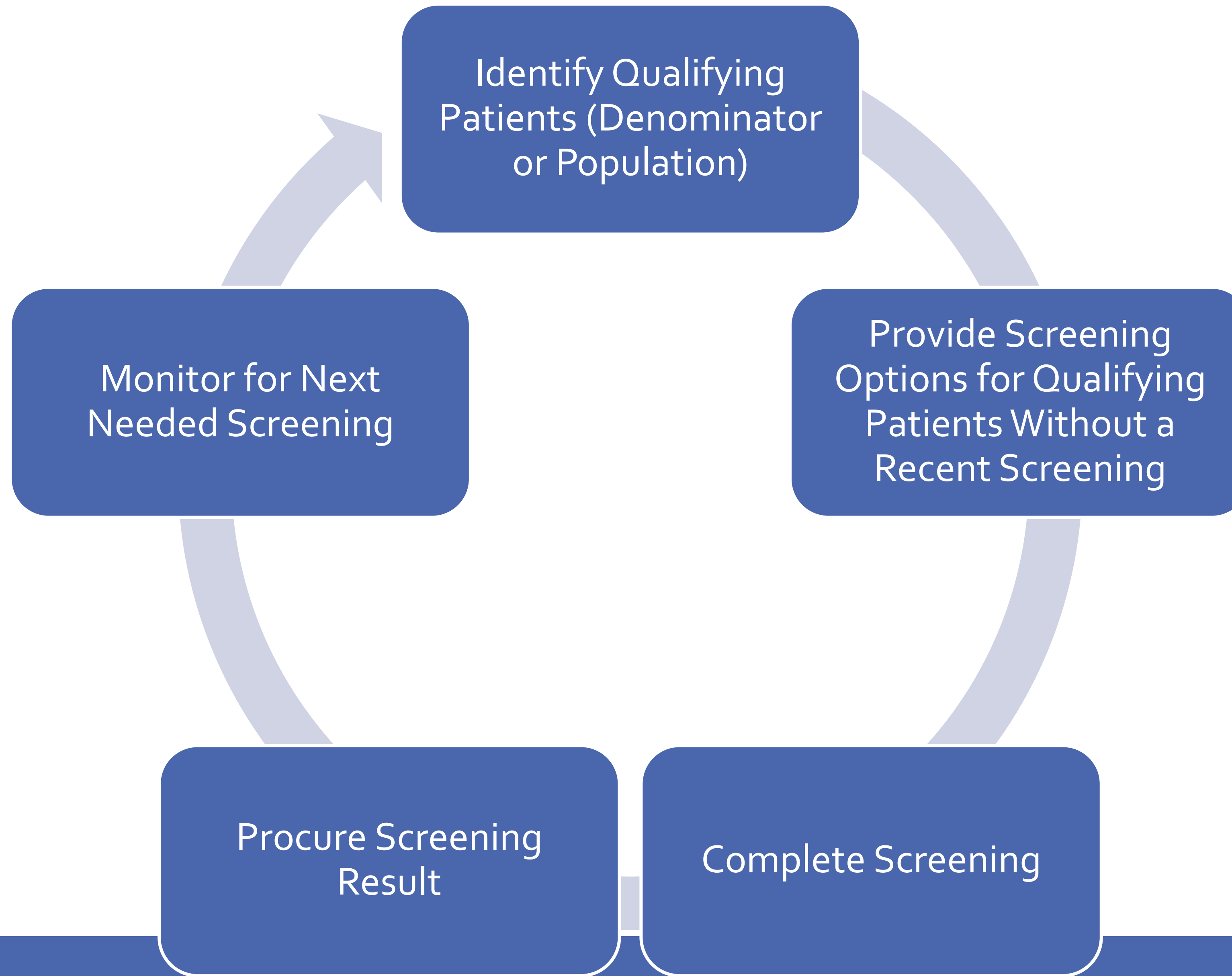
WORKSHOP 4: BUILDING A COMPLETE SCREENING SYSTEM

BUILDING A COMPLETE COLORECTAL CANCER SCREENING SYSTEM

Amanda Norton, MSW

R. Anthony Minervino Jr., MPA, MS, IHI-IA, PCMH-CCE

What is a "Complete System"?



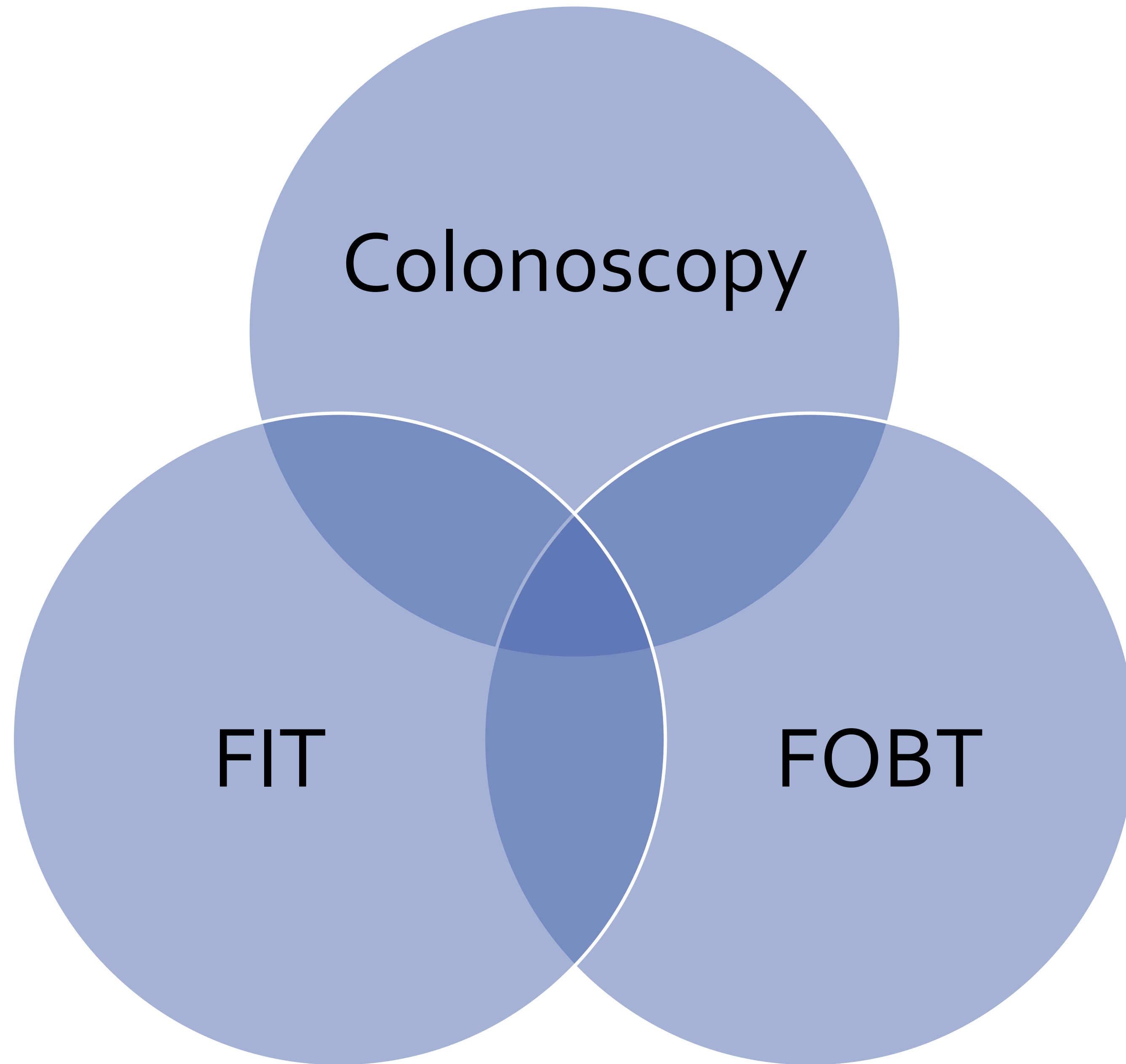
Identifying Patients in Need of Screening

- Registries or ad-hoc reports
- Pre-visit planning
- Insurance lists
- Point of care decision support
  - Care opportunities
  - Best practice alerts
  - Health maintenance
- Outreach to those not coming in for office encounters
  - Manual "gap work"
  - Automated like Phytel Outreach

Data Considerations

- Do the data representation (registry, report, etc.) and EHR “talk” to one another?
- Do you trust the data?
  - Is it mapped appropriately from discrete fields to know who is truly overdue?
  - Are practices simply scanning results into the chart, which aren’t reportable?
  - Is analysis of validated data correct?
- Do you have accurate contact information?
- Are the registry and insurance lists similar?
- Is colorectal cancer screening getting lost during pre-visit planning because of other priorities (patient or practice)?

SCREENING OPTIONS


Colonoscopy
FIT
FOBT

FOBT vs. FIT

FOBT

- Diet/medication restrictions
- Requires 3 samples
- Can be run in office
- Lower sensitivity
- Lesser patient compliance

FIT

- No diet/medication restrictions
- Generally only needs 1 sample
- Must be run in a lab
- Higher sensitivity
- Higher patient compliance

Colonoscopy

Pros

- The “gold standard”
- Providers tend to prefer this testing method
- If screening is negative, patient and practice receive a 10 year window until the next screening

Cons

- Patient aversion
- Burdensome to patients (invasive, logistics, etc.)
- Burdensome to staff (education/shared-decision making, etc.)
- It can be costly – if a polyp is found it automatically goes from screening to a diagnostic procedure

Stool-Based Screening

Pros

- Gives patients another option
- Non-invasive
- Lower cost to healthcare industry
- Less burdensome (prep, logistics, etc.)
- Once a patient has realized the benefits, the probability of using this method again is high

Cons

- Frequency (annual vs. every 10 years)
- Patient must return the stool collection kit and sometimes samples are unlabeled when received by the lab
- Patients who have previously disliked FOBT may not try the much easier FIT because of negative association
- Some providers will not endorse anything other than the colonoscopy

WHY AREN'T PATIENTS GETTING SCREENED?

Why patients aren't getting screened *(according to Physicians)*

Table 4 Perceived barriers by primary care physicians in Arizona to ordering CRC screening tests

Barriers	Ranked #1	Ranked #2	Ranked #3	Total votes (%)
Patient reluctance to undergo screening procedures	501	229	83	813 (83)
Patient fear of procedure or results	183	279	180	642 (65)
Patient lacks insurance coverage for screening procedure	188	147	173	508 (52)
Time constraints	42	55	107	204 (21)
Logistical problems for the patient	20	55	118	193 (20)
Lack of reimbursement for ordering or performing procedures	38	45	53	136 (14)
Decreased availability of screening tests	36	22	51	109 (11)
Other	27	7	17	51 (5)
Your familiarity with current guidelines	4	1	4	9 (1)

Cancer Causes Control.,2011

WHY PATIENTS AREN'T GETTING SCREENED
(ACCORDING TO PATIENTS)

"My doctor never talked to me about it!"

Recognize potential barriers to screening

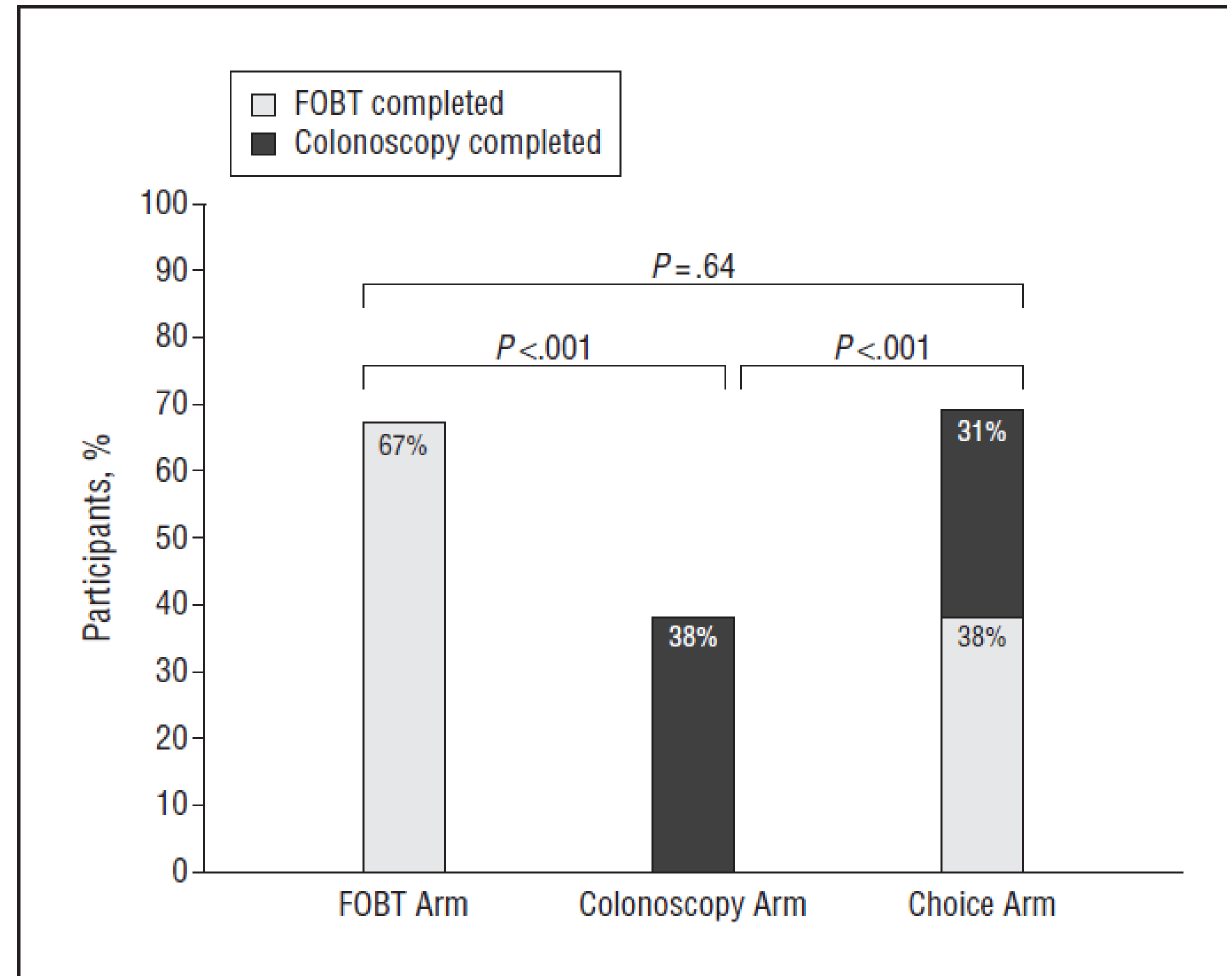
- Recommendation discussions must be sensitive to and address:
- Fear of cancer diagnosis
  - - Perception that cancer is a "death sentence"
- Lack of understanding of need for asymptomatic screening
- Misconceptions about cancer causes and risks
- Embarrassment
- Concern over discomfort
- Cultural issues
- Patient preferences

The Conversation

- Meet the patient where they are
- Identify gaps in health literacy, but don’t try to fill them all immediately
- Utilize
  - Motivational interviewing
  - Shared decision-making
- Utilize staff to support you (you might not have time for motivational interviewing…)

CHOICE MATTERS!

Patient Preferences



Inadomi, Arch Intern Med 2012

But… it doesn't matter how

Closing the Loop – Stool and Colonoscopy

- EMR data entry, workflows & staff responsibilities
- What's the next screening interval based on results (i.e. polyps identified during colonoscopy, blood found in FIT results)?
  - Can EHR accommodate changes in interval based on screening findings or family history?
- Who handles abnormal results and how (PCMH 5A)?
- Flagging & following up on overdue orders (PCMH 5A)
- Patient feedback

Discussion Questions

- How effective is your EHR and related tools at helping you to manage colorectal cancer screening (CRCS)?
- What kind of relationship do you have with insurance companies and are there opportunities to leverage them differently?
  - Assistance with facilitating screenings, claims data to supplement what's known otherwise
- What are barriers to FIT testing that you've witnessed and how have they or could they be overcome?
- What are barriers to colonoscopies that you've witnessed and how have they or could they be overcome?
- What are barriers to obtaining CRCS (colonoscopy or FIT) screening results and how have they or could they be overcome?
  - Results directly from testing facilities vs. results repositories like RHIOs