Increasing Colorectal Cancer Screening in New York State

WORKSHOP 1: UTILIZING YOUR EMR FOR PRACTICE IMPROVEMENT

May 15th, 2017
8:00AM – 4:30 PM
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

All of these specific activities are driven by one thing....
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
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.?
Increasing Colorectal Cancer Screening in New York State

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.

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 –

1. Patient Presents for Visit

2. Screening/Risk Assessment & Patient Education

3. Shared Decision Making with Patient

4. Meets Cancer Screening Criteria?
   - 4a. Screening not Indicated/ Patient Refused
   - 4b. Screening Test Completed

5. Results Received & Routed to Designated Person

6. Positive Findings?
   - NO
   - YES
     - 6a. Referral for Appropriate Intervention

Workflow after Screening is Completed

Nurse contacts patient with test results based on patient preferences documented in demographics in accordance with clinic’s current procedure

- **Results normal?**
  - **Yes**
  - **Abnormal (positive) test result communicated to patient via phone by provider along with GI or oncologist referral information**
  - Person who makes contact attempt must note this in progress notes in EMR
  - Able to reach patient?
    - **Yes**
      - Change Status to “reviewed” once results are communicated or final outreach step is completed.
    - **No**
      - After 3 attempts, certified letter should be sent by MA and noted within the Notes field of the Telephone Encounter.
      - Use Reason field to indicate CertLtrDelivered or something similar.
      - Close the Telephone Encounter
  - **No**

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

- 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

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
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?
Increasing Colorectal Cancer Screening in New York State

WORKSHOP 3: PATIENT OUTREACH AND ENGAGEMENT
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?
May 15th, 2017
8:00AM – 4:30 PM

Increasing Colorectal Cancer Screening in New York State

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”?  

1. Identify Qualifying Patients (Denominator or Population)  
2. Provide Screening Options for Qualifying Patients Without a Recent Screening  
3. Procure Screening Result  
4. Complete Screening  
5. Monitor for Next Needed Screening
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)?
## FOBT vs. FIT

<table>
<thead>
<tr>
<th>FOBT</th>
<th>FIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diet/medication restrictions</td>
<td>• No diet/medication restrictions</td>
</tr>
<tr>
<td>• Requires 3 samples</td>
<td>• Generally only needs 1 sample</td>
</tr>
<tr>
<td>• Can be run in office</td>
<td>• Must be run in a lab</td>
</tr>
<tr>
<td>• Lower sensitivity</td>
<td>• Higher sensitivity</td>
</tr>
<tr>
<td>• Lesser patient compliance</td>
<td>• Higher patient compliance</td>
</tr>
</tbody>
</table>

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)*

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

*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