COLORECTAL CANCER SCREENING BEST PRACTICES HANDBOOK FOR HOSPITALS AND HEALTH SYSTEMS

JULY 18, 2018
2:00 PM ET
Purpose of Today’s Webinar

• Introduce new NCCRT tool - *Colorectal Cancer Screening Best Practices: A Handbook for Hospitals and Health Systems*

• Review critical steps for hospitals and health systems to take in advancing CRC Screening efforts.

• Learn from two health system leaders about their experiences implementing CRC screening interventions.
NCCRT Resource Center
Moderators

Michael Potter, MD
Co-Chair, Professional Education & Practice Implementation Task Group
University of California, San Francisco

Dorry Lane, MD, MPH
Co-Chair, Professional Education & Practice Implementation Task Group
State University of New York
Stony Brook University School of Medicine

Presenters

Mary Doroshenk, MA
Strategic Director, Colorectal Cancer Intervention, American Cancer Society
Director, NCCRT

Andrew Albert, MD, MPH
Medical Director, Advocate Illinois Masonic Digestive Health Institute

Amanda Bohleber, MD
Medical Director, Deaconess Clinic
Colorectal Cancer Screening Best Practices

Handbook for Hospitals and Health Systems

Mary Doroshenk, MA
Director, NCCRT
Strategic Director, Colorectal Cancer Intervention
American Cancer Society, Inc.
Co-supported by the American Cancer Society and CDC

The National Colorectal Cancer Roundtable (NCCRT) is a national coalition of public, private, and voluntary organizations whose mission is to advance colorectal cancer control efforts by improving communication, coordination, and collaboration among health agencies, medical-professional organizations, and the public.

The ultimate goal of the Roundtable is to increase the use of proven colorectal cancer screening tests among the entire population for whom screening is appropriate.
NCCRT Tools and Resources

nccrt.org
Four Strategic Plan Goals to Achieve 80%

**Consumers**
*Move consumers to action*

**Policy**
*Increase access and remove barriers to screening*

**Systems**
*Use providers, hospitals, payers, employers to support screening*

**Process**
*Maintain momentum*
Vision for hospitals and health systems:

- Leverage the hospital system’s role as a respected health leader to promote and advocate for screening.
- Prioritize delivery of quality CRC screening across the continuum.
- Establish, disseminate, and monitor quality standards for programs and providers.
- Be a leader with other stakeholders, particularly primary care.
- Work with the underserved, particularly in partnership with FQHCs.
Challenges to this vision?

- Hospitals don’t always see themselves as beacons of preventive care or community leaders.
- Business model is not clear; hospitals face financial pressures, competition and mergers.
- They don’t have strong linkages to or feel they can impact primary care.
- There is fear of being overwhelmed by charity care and not having the capacity to meet this demand.
Challenges to this vision?

- Not sure who their patient base is.
- Get stuck on how to measure their rate/progress.
- Struggle with managing patient challenges.
- They don’t know how to reach patients who are underinsured/uninsured; can require cultural change.
NCCRT Resource Center
CRC Best Practices Handbook for Hospitals and Health Systems

What’s in the guide?

- Identifies 12 critical steps for hospitals
- Case studies describing strategies being used by individual hospitals and health systems
- Describes program origination, staffing, financial resources, activities, outcomes/impact, and lessons learned
- Provides advice on implementation
- Points to other resources
- Provides samples and templates from hospitals and health systems (e.g. CRC action plans, workflows, community and employee outreach materials, program evaluation tools)
12 Steps for Hospital and Health Systems

1. Build the Business Case for Colorectal Cancer Screening
2. Pick a Target Audience, and Consider an Employee-Focused Strategy
3. Determine Baseline Screening Rates, Evaluate Efforts and Track Impact
4. Partner with Community Organizations to Customize the Approach and Reach Underserved Patients

5. Use Screening Navigation
6. Offer Patients Multiple Screening Options
7. Provide Free or Reduced-Cost FIT Testing with a Clear Connection to Primary Care
8. Seek Deeper Engagement to Facilitate Personal Commitments to Screening

9. Employ Multi-Component Interventions
10. Remove Access Barriers for Average Risk Colonoscopies
11. Examine Workflow Issues to Reduce System-Based Barriers
12. Make Effective Use of Electronic Medical Records to Conduct Population Outreach
1. **Build the business case for colorectal cancer screening**

Screening is more cost effective than treating late-stage cancer, addresses community benefit requirements, fulfills COC standards, increases a hospital’s visibility and helps with attracting new patients.

2. **Pick a target audience, including consideration of an employee strategy**

The reach of hospitals is broad and includes primary care network, patient base, and community. Hospitals are also large employers able to reach area residents through employee outreach. Employee programs can pilot new approaches.
3. **Determine baseline screening rates, evaluate efforts, and track impact**

Measuring impact helps with program planning, obtaining outside financial support, and justifying organizational expenditures.

4. **Partner with community organizations to customize the approach and reach underserved patients**

FQHCs and community organizations provide knowledge of unique cultural or economic barriers, access points, and resources for referring and screening underserved patients.
Design the Program

5. **Use screening navigation**
   Hospitals that navigate patients effectively have dramatically higher show rates and proper prep. In some cases, navigation can be done by transitioning a nurse or other staff on a part-time basis.

6. **Offer patients multiple screening options**
   Research shows that promoting a choice of tests (e.g. colonoscopy, FIT, or DNA-based tests) increases odds that patients will complete screening.
7. Distribute FIT kits *with a clear connection to primary care*

Free FIT distribution programs with appropriate educational context and primary care referrals are opportunities to reach unaffiliated patients.

8. Seek deeper engagement to facilitate personal commitments to act

Signed pledges, culturally competent materials, and one-on-one consultation with clinicians deliver deeper engagement and high rates of follow-through on screening.
9. Employ multi-component interventions

CRC interventions that make use of two or more strategies has been shown to increase screening rates by a median of 15.4 percentage points.

10. Smooth the path for patients in need of average risk colonoscopy

Scheduling screening colonoscopies without first requiring a consultation (when medically appropriate) increases efficiency and patient show rates.
11. Examine workflow issues to maximize efficiency and impact

Key workflow issues that impact screening: clear guidance on staff roles and responsibilities, defined navigation process, follow-up on positive stool tests

12. Make effective use of electronic medical records for population outreach

Identifying primary care patients who are due for screening, sending out automated reminders, and alerting primary care providers to deliver a recommendation
Strategic Considerations

Adapted from the *Hospital Based Strategies for Creating a Culture of Health*, produced by the Robert Wood Johnson Foundation and the Health Research and Educational Trust.
Develop an Action Plan

Action Plan Worksheet

Name of Health System:

Colonial (CRC) screening goal:

Existing methods, processes, and programs that can be used to achieve the goal:

How will progress be checked and how often?

<table>
<thead>
<tr>
<th>Evidence-Based Strategies Chosen</th>
<th>Major Tasks to Implement Strategy</th>
<th>Expected Outcomes</th>
<th>Challenges and Potential Solutions</th>
<th>Person(s) Responsible</th>
<th>Due Date</th>
<th>Information or Resources Needed</th>
</tr>
</thead>
</table>
SAMPLES AND TEMPLATES: WORK FLOW

Figure 1: Work flow illustrating collaboration and contributions from Phoebe Putney, AAPHC, and the South Georgia Cancer Coalition
**SAMPLES AND TEMPLATES:**

**PATIENT QUESTIONNAIRE**

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<tr>
<th>Patient's Full Name:</th>
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<th>Have you ever had kidney failure or dialysis?</th>
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<th>Do you take insulin or diabetic medication?</th>
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<th>Have you ever been diagnosed with congestive heart failure?</th>
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<th>Do you have an implanted defibrillator?</th>
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<th>Do you have mitral valve prolapse or other heart valve problem?</th>
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<th>Have you had a heart attack or stroke in the past 2 months?</th>
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<th>Have you had a heart stent placed in the past 12 months?</th>
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<tr>
<th>Do you require oxygen at home for lung problems?</th>
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<tr>
<td>(As opposed to oxygen for sleep apnea, which would be acceptable)</td>
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<table>
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<tr>
<th>Do you have sleep apnea? Do you wear CPAP, BiPAP, or NIPPV?</th>
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<tr>
<th>Have you had unexplained chest pain or shortness of breath in the past 3 months?</th>
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<th>Do you weigh over 250 pounds (female): 300 pounds (male)?</th>
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<th>Have you had fever or felt ill in the past two weeks?</th>
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<th>Do you have an alcohol or other chemical dependency?</th>
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<th>Are you regularly taking any prescription pain medications?</th>
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<th>Are you allergic to latex?</th>
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<th>Have you ever had a colon polyp removed?</th>
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<th>Are you taking blood thinners other than aspirin? If yes, please mark all that apply on the list below:</th>
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<tr>
<th>Generic</th>
<th>Trade</th>
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<td>Acenocoumarol</td>
<td>Arixten</td>
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<td>Apixaban</td>
<td>Eliquis</td>
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<td>Dabigatran</td>
<td>Pradaxa</td>
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<tr>
<td>Fondaparinux</td>
<td>Fraxiparine</td>
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<tr>
<td>Argatroban</td>
<td>Arixtra</td>
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<tr>
<td>Clopidogrel</td>
<td>Plavix</td>
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<tr>
<td>Rivaroxaban</td>
<td>Xarelto</td>
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<td>Ticagrelor</td>
<td>Brilinta</td>
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<tr>
<td>Ticlopidine</td>
<td>Tildix</td>
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<tr>
<td>Coumadin</td>
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Please fill out and print this form and either:
1. Mail it to Surgery Scheduling via interoffice mail
2. Fax it to LIT, BRIT
Are you at RISK for colon cancer?

Drive Thru
Colorectal Cancer Screening

Please note the 2013 screening location change to Blessing Hospital at 14th Street. Enter via Vermont Street ramp driveway. No entrance from Broadway.

Wednesday, March 20 • 11 a.m. - 2 p.m.

Kits must be picked up by the person using the kit, consent form signature is required.

Pick up your free screening kit, no appointment, no cost.

Brought to you by the Regional Cancer Partnership of Illinois. This project was made possible through funding from the Illinois Department of Public Health.

BLESSING Cancer Center
Improving Your Life
For more information call 217-223-8400, ext. 7718
blessinghealthsystem.org
SAMPLES AND TEMPLATES: EMR ALERT

Figure 2: Geisinger EMR Best Practice Alert for CRC
Hospital Achievements

• Increased screening rates among employees and primary care patients
• Increased new patients coming in through primary care networks, thanks to screening outreach
• Increased hospital visibility thanks to expanded community engagement
• Improved efficiency around colonoscopy scheduling and completion; fewer no-shows, better prep
• Reduced costs associated with treating uninsured in the ER dropped
• Increased screening rates among medically underserved in the community
NCCRT Hospital & Health System Webinar
Andrew Albert, MD MPH
Digestive Health Institute - Illinois Masonic Medical Center
July 18, 2018
When we heard this morning of Jennifer Bracey's passing I had to think back to our Call on Congress event and reflect on meeting Jennifer. There are so many people you connect with at these events however there are always a few who have that extra spark that makes you want to do more and inspires you. Jennifer was an inspiration and we will always remember your Fight Colorectal Cancer community will continue your fight, count on it!

@BEAUTIFULMUMSIE
@BEAUTIFULMUMSIE

Replying to @DrAndrewAlbert

I whole heartedly agree. If my daughter Laura @paperdollybird had been listened to & screened she would be here with us today. We need to do more to make this happen.

7/5/18, 4:52 PM
Current Screening Process
Colon Cancer Screening: A stakeholder problem

• Payers – Member health and cost of care
• Hospitals and administration - contracts and culture of care
• Endoscopy Centers – open time/inefficiency
• Gastroenterologists – overbooked and procedure focused
• **Referring PCPs – compliance and barriers to care**
• Patients – day off work, cost, fear unknown
• Families – unsupportive or unavailable
PCP Road Show – July 2014

- Patient dissatisfaction with process of calling and scheduling
- PCP faces Issues with compliance (distance, insurance coverage)
- PCP frustrated by poor communication
  - Hospital to PCP
  - GI to PCP
- Unforeseen impact:
  - procedure census lower
  - hospital revenue lost
  - leakage to competitor hospital
  - impact ACO
  - safety issue
DASC Program

- Direct Access Screening Colonoscopy Program
- Aligned one gastroenterology group/Advocate practice location
- How it works:
  - PCP office faxes patient info with H and P
  - RN navigator reviews H and P (excludes some)
  - Patient directly scheduled for Colonoscopy
  - MD performs procedure and conveys results
  - Pathology and Scope reports sent to PCP and GI
  - Patients with advanced disease "navigated" to oncology or surgery
  - Referral loop is closed
DASC Requisition and Tracking
Patient Materials

Digestive Health Services
What You Need to Know for Your Procedure

Your Registration
- Please arrive for registration one hour prior to your appointment.
- Check in at the main information desk in the Center for Advanced Care.
- You will be directed to Digestive Health on the 1st floor of the Center for Advanced Care.
- You will be asked to complete a few registration forms, as well as provide insurance information, such as a driver’s license or state ID, and your credit card.
- You will be on a shuttle to your procedure.
- Free valet parking is available for all patients.

Make Sure You Have an Escort
To ensure your safety, you must have a companion with you at all times. The person who will accompany you will be in the recovery area waiting for you. If you need transportation when you are ready for discharge, please have your companion leave their name and contact information with the nurses. Please be sure that you will be able to drive on your own. If not, you will be assessed and if you do not have an appropriate means, we will make arrangements for transportation on a subsidized basis.

What to Expect
- You will be taken to a recovery area in a hospital gown and your personal belongings will be collected for you. Please leave your valuables, such as jewels or personal electronics, at home.
- Prior to your procedure, you will receive instructions for prescription medications. You should not be overmedicated.
- You will be instructed to drink water approximately 36 hours prior to the procedure. Your physician may take your sedatives, or laxatives, at home, allowing you to drink water.

Recovery Period
Following your procedure, you will be taken to the recovery area, where you will rest for approximately 45 minutes. Your vitals will be monitored throughout your stay.
- Gastroscopy—Your colon will have been examined with a camera during your procedure, so you will be encouraged to eat light while in recovery.
- Upper Endoscopy—You may feel bloated following your procedure, so you should not eat anything before you leave.

Going Home
You will receive instructions and important contact information before you leave. You will not be able to drive, operate machinery, or be around alcohol until 36 hours after your procedure. You may eat anything you choose, however, you should not drink alcohol, beverages, or foods for 36 hours following your procedure.

Bowel Preparation for Colonoscopy

INSTRUCTIONS

For seven days prior to your colonoscopy, do not take any blood thinning medications. This includes aspirin, plaquenil, coumadin, plavix, vitamin E, and folic acid. If your colonoscopy is less than seven days away, stop taking any blood thinning medications starting now. If you have any kidney problems, please confirm with your primary doctor that it is okay to take this bowel preparation.

The day before your scheduled colonoscopy:
- You must stop all solid foods and begin a clear liquid diet in the morning. A clear liquid diet is any liquid you can see through. This includes apple juice, prune juice, 7-Up or Sprite, water, clear soups, juices, clear broths, gelatin, milk, or any clear liquid. No dairy products or cruciferous vegetables are allowed.
- You cannot have dairy, orange juice or any juice with pulp or sediment. Do not drink anything red or purple until after the procedure.
- Continue the clear liquid diet for the rest of the day.
- At 8PM, take the first dose of your Golytely Bowel Preparation. Drink the preparation one glass at a time until you finish it at the container. You may rinse but having the medication chilled makes it easier to drink. You can mix the medication with 7-Up to improve the taste.
- At 12PM, take the second dose of your Golytely Bowel Preparation. Drink the preparation one glass at a time until you finish the second 8 of the container.
- Continue drinking clear liquids during your prep until midnight. Nothing to eat or drink after midnight.

The day of your colonoscopy:
- Do not eat or drink anything.
- If you are taking medication for your blood pressure or heart, take your morning medications with a sip of water. If you are a diabetic, take 1/2 your normal dose of diabetic medication.
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<th>Time</th>
<th>Dr. A (Monday)</th>
<th>Dr. B (Tuesday)</th>
<th>Dr. C (Thursday)</th>
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Forward thinking...
The Answer: DASC

- To accommodate healthy patients needing screening colonoscopy
- To expedite and simplify the process of scheduling colonoscopies
- Reduce wait time from 6 months to 2-3 weeks
- Increase access, skipping traditional face-to-face consultation with gastroenterologist
- Provide a worry-free, fully navigated experience for patients
- Create a closed loop of communication between providers and referring MDs
- Facilitate quality growth and efficient scheduling
CRC Screening Rates
Advocate Physician Partners (PHO)
AIMMC Clinical Integration Rates

July 2014: 26%
July 2015: 30%
July 2016: 69%

DASC implemented July 2015

50-65

>65

TOMORROW STARTS TODAY.
DASC: July 2015 to October 2016

- Patients referred: n=735
  - Included: n=429
    - Completed: n=323
      - Normal: n=218
      - Adenoma: n=98
      - Advanced adenoma: n=2
      - Cancer: n=5
    - In process: n=106
  - Excluded: n=306
    - Referred elsewhere: n=53
    - Patient Refusal: n=116
    - Formal GI eval: n=137

Nurse Navigated DASC ADR= 32.5%
ASGE ADR= 25%
Unforeseen Benefits

- Increased referrals to Oncology, Radiology, Surgery, Ancillary svcs
- Utilized DASC for ACO
- Increased goal to 70% for 13 hospitals
- Eliminate leakage across service lines
- Safer practice of medicine in FFV culture
Stakeholders win!

- Patients
  - Decrease barriers (time, money, distance, fear)
- PCPs
  - Timely access for screening
  - Closes the loop for results/follow up
- GIs
  - Decrease pre-procedure consults
  - Maximize procedural block time
- GI lab
  - More efficient use of staff time/predictable
- Hospital/Administration
  - Volumes increase -> Revenue
  - Safety improved -> ACO measures more ambitious
- System
  - Decreased leakage
Case Study

- 60 year old Cantonese patient
- Wellness visit with PCP -> FOBT+
- Referred to DASC
- Contacted patient via interpreter to schedule appointment
- Colonoscopy done- his first one!
  - One 10 mm polyp in the cecum
  - Two 8 to 12 mm polyps in the transverse colon
  - Two 20 mm polyps in the descending colon (1 with Adenocarcinoma)
  - One 14 mm polyp in the proximal sigmoid colon
- Colon resection done- CURED!
Conclusions

• DASC works
• Identify your barriers in the process
• Come up with your own solution (out of the box)
• Identify all stakeholders involved
• Engage stakeholders in your planning process
• Demonstrate success and build upon it
• Whatever you do...do something!
Thank you!
Engagement, Education, Early Detection is Key

Shared Goal: Reaching 80% Screened for Colorectal Cancer by 2018
Deaconess Health System
Evansville, Indiana
Amanda Bohleber, MD, FAAFP
Medical Director, Deaconess Clinic
Deaconess Health System
Evansville, Indiana

- Not-for-profit, governed by a local board of directors
- 50,000 Discharges annually
- 99,000 Emergency department visits
- $900 million in net revenues
- 5000+ employees
- 63% market share in primary area
- Approximately 2000 analytic cases/year
Engagement

Senior Administration
- President & CEO – Health System
- VP, Deaconess Clinic
- Medical Director, Deaconess Clinic
- Medical Director, Deaconess Clinic-GI Department
- Oncology Committee Chair
- Surgeon
- Nursing Leadership

Clinical Team
- Primary Care Physicians
- Practice Managers
- Health Coaches
- Office Nurses
- Community Engagement Specialist
- Population Health Teams-Deaconess’s ACO
Education
Program Activities- Three Year Plan

• **Year 1**
  – Increase awareness and education both providers, clinicians, and patients of Deaconess’s commitment to the 80% by 2018 pledge
  – Population Health teams collaborated to mine EHR for relevant data to establish baseline screening rates for Deaconess Clinic patients
  – Laboratory Department – evaluate current screening tools/kits

• **Year 2**
  – Focus on PCP workflows and quality indicators
  – Leverage EHR to identify screening processes and gaps in practice
  – Continue education internal and external

• **Year 3**
  – Colorectal Cancer Awareness Seminar
  – Continue Deaconess Clinic Quality Indicator
  – Continue Population Health Management initiatives
Blissfully ignorant:
* Kick-off meetings
* Report build & validation
* GI Physicians own EMR updates
* Pledge awareness campaign
* Rally the troops & community

Colorectal Cancer Screening Rate Trend
12/2015 to 7/2018
60+ PCPs 35,000 Patients
Colorectal Cancer Screening Rate Trend
12/2015 to 7/2018
60+ PCPs 35,000 Patients

We will succeed:
* Physicians put CRCs 80% on their at-risk Quality Comp plan
* CRCs 80% incentive alignment across entire health system
* HRA $$S for employees completing screening
* 5,500+ Open Care Gap Letters sent directly to patients
### Key Takeaways

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<tr>
<th>Activities</th>
<th>Resources</th>
<th>Impact</th>
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<tr>
<td>Community outreach and education</td>
<td>Community Engagement Specialist</td>
<td>Medicare screening rate 80.32% by 2018!!</td>
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<tr>
<td>Pledge – engaged leadership and physicians in a shared goal</td>
<td>Clinical Informatics for EMR Optimization</td>
<td>All payers combined rate currently 76%......we will get there!</td>
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<td>EMR reporting, validation, and optimization</td>
<td>Physician and Administrative Champions</td>
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<tr>
<td>System-wide clinical practice guideline endorsed by physicians</td>
<td>Population Health Teams</td>
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<tr>
<td>Incentive alignment – every employee invested/rewarded</td>
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<td>Data transparency – physician compare, patients aware</td>
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<td>Care gap lists</td>
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</tbody>
</table>
Please submit your questions in the chat box.
Thank You!

Thank you to the 12 systems featured in the guide!

- Advocate Illinois Masonic Medical Center
- Advocate Sherman Hospital
- Blessing Hospital
- CentraState Healthcare System
- Deaconess Health System
- Gelseiner Health System
- KentuckyOne Health
- Orange Coast Memorial
- Phoebe Putney Memorial Hospital
- Southwest General Health Center
- SSM Health
- Surgery on Sunday, Louisville, Inc.

Additional thanks to the Handbook Advisory Group and to today’s speakers!

This handbook was supported by the Grant or Cooperative Agreement Number DP004969-04, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.
Thank You!

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