Thank you for joining! The session will begin shortly.
The Critical Role of Primary Care: Updates to the NCCRT Steps Manual and Leveraging the Power of Professional Societies to Advance Colorectal Cancer Screening

Tuesday, November 16, 3:00 PM
The Critical Role of Primary Care

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Newly Updated Steps Guide for Increasing CRC Screening:
A Manual for Primary Care
Michelle Tropper, MPH
November 16, 2021
Overview

• Approach to updating the Steps Guide and Advisory Committee Process
• Updates include:
  ✓ New screening modalities included (mt-sDNA, CT Colonography and high-sensitivity stool testing)
  ✓ Updated literature review / annotated bibliography
  ✓ Updated screening guidelines
  ✓ New appendices and tools
  ✓ Geared to all primary care audiences
• 10 Interviews and Case Studies
• Abnormal stool tests: NCCRT Best Practices Brief
How the Guide has been used

- Credible reference to brainstorm ideas
- Identify evidence-based recommendations to increase screening rates
- Identify ways to pay for colorectal cancer screening
- Flu-FIT
- Identify tested messages
- Generate ideas for tracking follow-up and provider
- Guideline resource
## Most helpful / What to include (Content)

<table>
<thead>
<tr>
<th>Most Helpful</th>
<th>What to include in revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step-by-step guide of what to do</td>
<td>Greater emphasis on patient navigation beyond the separate navigation guide.</td>
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<tr>
<td>Ability to assign team members to steps</td>
<td>More input from rural component</td>
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<tr>
<td>Tested messages that could be replicated in practice</td>
<td>Video and virtual tutorials to address different learning styles</td>
</tr>
<tr>
<td>Patient instructions on how to do FOBT/ FIT</td>
<td>How to regain engagement post-COVID and catch up with backlog; how to rebound from the decline in screening rates</td>
</tr>
<tr>
<td>Information on how to identify patients who need to be screened</td>
<td>Tested messages and text reminders for patient reminders</td>
</tr>
<tr>
<td>Guidelines/Overview of screening process</td>
<td>Algorithm / process to help identify patients eligible and due for screening</td>
</tr>
<tr>
<td>Epic users would like to see more information specific to their EHR (i.e., smart phrases and reports developed by others that could be replicated)</td>
<td></td>
</tr>
</tbody>
</table>
Updated Steps

**Step #1: Make a Plan**
- Included steps for data validation and readiness assessment and clinical decision support for quality improvement

**Step #2: Assemble a Team**
- Included steps for an Internal Cross Functional Team
- Added Step for Reviewing workflows and identifying opportunities

**Step #3: Get Patients Screened**
- Added documentation of results in EHR

**Step #4: Coordinate Care across Continuum**
- Included process for follow-up with patients for any abnormal results

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**Coordinate Follow-up after abnormal results**
- Contact patient with abnormal results by phone
- Send letter informing patient by mail
- Schedule follow-up appointment

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**Create an Internal Cross Functional Team**
- Executive Champion
- Identify a key leader
- Include Cross-functional members

**Prepare the Patient**
- Provide patient education
- Follow-up plan

**Make a Recommendation**
- Follow-up does not seem necessary

**Design Your Practice’s Screening Strategy**
- Close may not be the same as good
- Close should follow
- Implement a formal referral system

**Review workflows and identify opportunities**
- Document current state of workflows
- Identify opportunities for enhancements

**Partner with Colonoscopy**
- Identify colonoscopy champion

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**Document Results in the EHR**
- EHR report

**Follow-up**
- Community review

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**Measure and Improve Performance**
- Track completion rates and follow-up

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HealthEfficient
Steps Guide Refresh – Highlights

New Appendices:

a. New NCCRT Colonoscopy Needs calculator
   https://learning.nccrt.org/colonoscopy-calculator-form/

b. Readiness Assessment Tools for Practices:
   i. HealthEfficient Colorectal Clinical Decision Support for Quality Improvement (CDSQI) Example
   ii. West Virginia Partnership to Increase Colorectal Cancer Screening (WV PICCS) Partner Clinic Readiness Assessment Toolkit
   iii. New York State Colorectal Cancer Clinic Readiness Assessment Tool

c. FIT/FOBT Sample Workflow Process

d. Updated EHR Workflow Documentation Screenshots
10 Case studies and appendices:

1) Allegheny Health Network Premier Medical Associates
2) Coal Country Community Health Center
3) East Boston Neighborhood Health Center
4) Family Medical and Counseling Services
5) Mercy Health System
6) NOELA Community Health Center
7) North Hudson Community Health Center
8) Sanford Health
9) Triburcio Vasquez Health Center
10) Zufall Community Health Center
# Case Study Innovations and Tools Shared

<table>
<thead>
<tr>
<th>Patient Navigators/Community Health Worker</th>
<th>Dashboard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailed FIT</td>
<td>Abnormal FIT results follow-up</td>
</tr>
<tr>
<td>HIT Intervention</td>
<td>Patient and/or Provider Education</td>
</tr>
<tr>
<td>Care Team</td>
<td>Reminders</td>
</tr>
<tr>
<td>Clinical Champion</td>
<td>Outreach</td>
</tr>
<tr>
<td>Open Scheduling</td>
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</tr>
</tbody>
</table>
Thank you to all who shared and contributed to the updated Steps Guide!

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Georgia Cancer Control Program

- CDC grant (part of national ScreenOutCancer initiative) awarded to increase CRC screening for areas of need in South Georgia.
- Implement evidence based interventions for sustainable improvement
- Goal to implement in 15 clinics across the southern region of Georgia (7 enrolled to date)
- Goal (short-term) minimum 60% screening rates. Ultimately: 80%
- Utilize many of the same strategies outlines in the Steps Manual
Plan

• Baseline Rates
  • PopulationManager by Forward Health Group
    • Identify patients in need of screening
  • Validate through EHR

• Need community buy-in/partnership
  • AAPHC and Phoebe Putney Memorial Health System

• FIT First (or other stool based-testing)
• Horizons Patient Navigation
  • Most effective intervention
  • For colonoscopies: 2% no show, less than 5% inadequate prep
• Dawson Medical Center
  • Terrell County – highest rate of colon cancer mortality in the country 2007
  • 1st implemented under grant
  • Baseline screening rate (Feb ’21) – 56.1%
  • Current rate: 64.9%
  • Navigated FIT Tests: 78% return rate
  • Challenge: initiating the referrals

• Champions
  • Physician and Clinic

• Hospital System Partnership
  • HCCRT Colonoscopy Calculator

• Evidence Based Interventions
  • Provider Reminders
    • EHR reminders, eCW “sticky notes”, chief complaint issues
  • Patient Reminders
    • Targeted reminders using EHR
  • Provider Assessment & Feedback
    • Quality Improvement – Key Performance Indicators
    • By clinic and sub-divided into care teams
  • Reducing Structural Barriers
    • Transport, literacy, technology, costs
Screening/Sustainability

• Horizons Patient Navigation
  • EBI’s funnel into navigation
  • Provide education material
  • Prepare/inform patients
  • Track return rates and follow up

• Clinical Workflow Changes
  • AAPHC CRC policies, referral systems, order sets
  • “Establish a medical neighborhood”

• Challenges
  • COVID-19
    • Increased Patient Load
    • “Denominator dilemma”
    • Colonoscopy Wait Times
      • Requirements of COVID testing
  • Mail – FIT Tests
    • Slow shipping
    • Lost/non-viable samples
  • Physician Fatigue
    • Demands of EHR, ease of ordering diagnostic tests/labs
    • Click burden
    • Order Sets – facilitated referrals to navigation
  • Screening age change
    • Education & Outreach for new age group
FIT FIRST

High value colon cancer detection

Dr. Jim Rogers, MD, FACP
**Performance Status:**
- Calendar Year 2019 all patients = 60.4% screened
- Calendar Year to Date 2021 Medicare patients = 76% screened

**Approaches to Screening**

**Opportunistic**
- one clinician interacting with one patient

**Programmatic**
- system-wide, organized plan offering screening to a population

**Patient Population:** MA and ACO patients with a Mercy PCP

**Patients due for screening and without a visit scheduled for remainder of CY21:** 32,358
- 32,107 Average Risk
- 251 Above-average Risk (IBD, Lynch, Familial Polyposis etc.)
Pandemic Delays

out of service 2-5 mo’s, long scheduling delays

Manpower Shortage

Skilled scope-ist = 1,728 – 2,106 year (1,917)
  8-10 screenings/day
  4.5 days/week
  48 weeks/year
# of FTE’s needed for screening = 32.44 FTE’s
  (Rescope @ 10%/yr = 9.9 FTE’s)
American Cancer Society Guidelines

• Any of the recommended screening options can be used. “best test is the one done”
  - Colonoscopy every 10 years
  - Flex sig every 5 years
  - CT colonography every 5
  - Multi-target stool DNA every 3 years
  - FIT or HSGFOBT annually
Model-estimated Benefit CRC Screening by Starting Age

Model-estimated Life Years Gained from CRC Screening Starting at Aged 45y vs 50y, per 1000 Screened Over a Lifetime

<table>
<thead>
<tr>
<th>Test</th>
<th>MCR Fee</th>
<th>Fee sch</th>
<th>Yearly cost MCR/Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy 10 yrs</td>
<td>$994</td>
<td>$1109*</td>
<td>99.40/110.90*</td>
</tr>
<tr>
<td>Flex Sig 5 yrs</td>
<td>$158.57*</td>
<td>$324*</td>
<td>31.74/64.80*</td>
</tr>
<tr>
<td>CT colonography 5 yrs</td>
<td>$117.75*</td>
<td>$462*</td>
<td>23.55/92.40*</td>
</tr>
<tr>
<td>DNA stool 3 yrs (Cologuard)</td>
<td>$508.87</td>
<td>$1098</td>
<td>169.62/366</td>
</tr>
<tr>
<td>FIT 1 yr</td>
<td>$18.05</td>
<td>$66</td>
<td>18.05/66</td>
</tr>
<tr>
<td>FOBT 1 yr</td>
<td>$15.92</td>
<td>$66</td>
<td>15.92/66</td>
</tr>
</tbody>
</table>

* Does not include facility fees
“Get Health Care Right”  
Sister Catherine McAuley

- Get the rates up & colon cancer down
  - We must get more screened
- Get the value right
  - Consider costs
    - Economic
    - Morbidity
    - Mortality
- Get the process right
  - Driven by value and patient guidance
How the AAMA Became a Dedicated Partner of the NCCRT in the “80% in Every Community” Initiative

THE AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS® (AAMA)

DEBORAH NOVAK, CMA (AAMA), VICE PRESIDENT

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NOVEMBER 2021
Medical assistants and the AAMA

Medical assistants work in outpatient settings and perform both back-office clinical and front-office administrative duties.

60% of CMAs (AAMA) work in primary care.

The American Association of Medical Assistants (AAMA) represents over 90,000 medical assistants throughout the United States.
Why CRC screening?

There are many worthy public health causes (e.g., preventing alcohol-exposed pregnancies and FASDs).

AAMA national and state leaders were encountering a number of tragic colorectal cancer situations in their professional and personal lives.

They realized that medical assistants could make a significant difference in increasing CRC screening rates.
How medical assistants make a difference

OFTEN MEDICAL ASSISTANTS ARE “COMMUNICATION INTERMEDIARIES” BETWEEN PROVIDERS AND PATIENTS.

FOR EXAMPLE, MEDICAL ASSISTANTS ARE OFTEN ASSIGNED PATIENT EDUCATION.

MEDICAL ASSISTANTS ARE ASSUMING PATIENT NAVIGATOR AND PATIENT ADVOCATE ROLES.
Strategies

AAMA continuing education courses and articles in CMA Today were geared toward empowering medical assistants to be more effective advocates for CRC screening.

The focus intensified during CRC Awareness Month and Medical Assistants Recognition Week.

Medical Assistants’ Role in Improving CRC Screening Rates: Getting to 80%; Durado Brooks, MD, MPH
Results

3,964 health professionals successfully completed the course for AAMA CEU credit.

AAMA posts in Facebook, Instagram, LinkedIn, and Twitter resulted in 183,613 impressions.

AAMA state societies, local chapters, and academic programs created their own CRC screening educational events, thus multiplying the impact.
Medical assistant managers used NCCRT materials and information to provide in-service training for staff.

They also used NCCRT materials as a basis for role playing so staff would be more comfortable talking with patients about CRC screening.
Thoughts for other professional societies

Don’t underestimate the generosity and commitment of health professionals. They are often motivated by noble challenges.


Verifying CRC screening should become just as integral a component of primary care practice as verifying patient immunizations.
Questions & Answers
See You Tomorrow!