2022 NCCRT Annual Meeting

FOLLOW UP TO ABNORMAL NON-COLONOSCOPY TESTING
Follow Up to Abnormal Non-Colonoscopy Testing

Francis R. Colangelo
MD, MS-HQS, FACP
Director, Outcomes Office, Allegheny Health Network

David Lieberman
MD
Professor of Medicine, Oregon Health and Science University

Molly McDonnell
Director of Advocacy, Fight Colorectal Cancer

Elizabeth Ciemins
PhD, MPH, MA
Vice President, Research & Analytics, AMGA
The Policy Landscape

Thursday, November 17, 11:00 AM
Follow-Up Colonoscopy: The Policy Landscape

Molly McDonnell
Director of Advocacy
Fight Colorectal Cancer
**Policy Change**

The key to changing cancer is through advocacy, policy and research.

From day one the focus of Fight CRC has been to get the voices of advocates heard.

**Research Endeavors**

It takes thought leaders, experts, and advocates working together to move research forward.

We’re focused on funding promising, high-impact research.

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**Patient Support**

A cancer diagnosis is scary. We believe no one fights alone.

Whether you’re a patient, caregiver, or friend, we’re here for you.
Catalyst State-by-State Advocacy Program

Fight CRC’s Catalyst Program aims to accelerate progress toward turning aspirational colorectal cancer screening goals into reality by increasing access and reducing barriers to colorectal cancer screening. Specifically,

- Remove patient cost-sharing for follow-up colonoscopies following a positive non-invasive CRC screening test for insured populations.
- Ensure coverage for insured populations to include 45-49 years old, as is now recommended through American Cancer Society & USPSTF guidelines.
Catalyst Advisory Council

Strategic Partners & Sponsors

CDC
American Cancer Society Cancer Action Network
prevent cancer

ACHII
INSPIRING HEALTHY ACTS

NO
SHAVE
NOVEMBER

AGA
American Gastroenterological Association

EXACT
SCIENCES

Genentech

Bristol Myers Squibb
State Follow-Up Policy Landscape

- Legislation passed
- Legislation pending
- Catalyst Grantee State

FIGHTCRC.ORG
Follow-Up Colonoscopy Policy Efforts

- Medicare Loophole Bill First Introduced (2012)
- States Advance Follow-up Legislation (2015-2022)
- December 2020: Medicare Loophole Bill Signed into Law
- January 2022: Commercial Plan Guidance on Follow-up Colonoscopy
- July 2022: CMS Proposed Rule on Follow-up Colonoscopy
- November 2022: CMS Final Rule on Follow-up Colonoscopy
ACA Compliant Plans

Medicare

Medicaid Expansion Population

Traditional Medicaid Population

Grandfathered Plans

Uninsured

Follow-Up Colonoscopy Coverage
Over the past two years we’ve seen incredible policy wins, now it’s our job to ensure that patients actually benefit.
Advancing legislation to remove patient cost-sharing for colonoscopy following a positive non-invasive screening test.

Introducing and advancing legislation to remove out-of-pocket costs for colonoscopy following a positive non-invasive screening test.

Fight CRC will be awarding a limited number of smaller grants in 2023 for states interested in building capacity for policy work around colorectal cancer screening.
Looking Ahead: Federal Work

Expand the CDC Colorectal Cancer Control Program

**Build on Existing Success**

Increase funding for the CDC’s Colorectal Cancer Control Program so it can expand to all 50 states

**Leverage Successful Models**

Provide eligibility for treatment through Medicaid for those diagnosed through the CRCCP as the Breast & Cervical Cancer Prevention & Treatment Act did
Thank You!
Closing the Screening Continuum: Updates from the American Gastroenterological Association

Thursday, November 17, 11:00 AM
AGA CRC Screening Initiative

David Liebermann
Professor of Medicine; Division of Gastroenterology
Oregon Health and Science University
AGA Screening Initiative Task Force

Defined the continuum of CRC screening which includes:

- Identification of high-risk patients
- Follow-up of non-invasive screening tests
- Follow-up of high-risk patients after colonoscopy

Published AGA Policy Statements on CRC Screening in *Gastroenterology* June 2022

Launched Executive Committee on CRC Aug. 2021
Continuum of CRC screening

Non-Invasive Test completed

Primary Screen With Colonoscopy

(+) Test
Biden Administration Issued Guidance requiring private health plans to cover the follow-up colonoscopy necessary after a non-invasive screening.

January 2022

Medicare & private payers must cover screening colonoscopy resulting in polypectomy - phase-in

July 2022

CMS proposed covering the follow-up colonoscopy after a positive stool-based CRC screening test.
Phase II Screening Initiative

Improving Adherence
### Vision, hopes, dreams

#### Table 4. Estimated Impact of Increasing Population-Wide Colorectal Cancer Screening Uptake in the United States, Based on Mean Results From 4 Established Screening Models

<table>
<thead>
<tr>
<th>Total CRC screening uptake in the population</th>
<th>Colonoscopy uptake (absolute rate), a %</th>
<th>FIT uptake (absolute rate), a %</th>
<th>CRC cases averted, %</th>
<th>CRC deaths averted, %</th>
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<tbody>
<tr>
<td>65%</td>
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<td>10</td>
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<tr>
<td>85%</td>
<td>75%</td>
<td>10</td>
<td>62</td>
<td>70</td>
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</table>

*a* Assuming that those taking up screening do so with full participation over time with screening, follow-up, and surveillance.

*b* Approximate current prevalence of screening among age-eligible individuals aged 45–75 years.

Lieberman, Ladabaum et al; Gastroenterol 2022; 163(2):520-526
Challenges to Screening

- Education/awareness
- Access to initial screening
- Adherence when screening offered
- Disparities
- Barriers
  - Socio-economic
  - Access to health care
  - Transportation if colonoscopy needed
  - Time away from work
  - Childcare and elder care responsibilities
  - Disparities
Successful Screening Models

Successful programs

- Kaiser, California – achieved >80% adherence with subsequent reduction in CRC incidence, mortality and elimination of disparities (Doubeni, 2022)
- C-5 in NYC – achieved high levels of adherence in diverse populations

Lessons from successful programs

- Create access
- Develop effective education/communication
- Provide navigation
What is navigation?

- Education; answer questions
- Provide access to test
- Reminders to complete test
- Navigate to colonoscopy if non-invasive test is (+)
- Help with barriers such as
  - Transportation
  - Time off work
  - Child-care, elder care
CRC Screening Rates

American Cancer Society Goal: 80% by 2018

Levin et al; Gastroenterol 2018; DOI 10.1053/j.gastro.2018.07.017
CRC Mortality

Levin et al; Gastroenterol 2018; DOI 10.1053/j.gastro.2018.07.017
CRC Incidence- Late Stage CRC

Doubeni et al; NEJM 2022; 386:796-9
Piloting success

Develop local pilot CRC programs

- Access
- Coverage of screening continuum
- Education & Outreach
- Navigation
- Engage key partners
- Break down barriers like transportation
- Address screening disparities, health equity
Proposed approach

Develop pilot framework

Screening continuum

Access and coverage

Navigators

Partner with health care stakeholders

Industry
- Non-invasive screening test companies
- Endoscopy companies

Payers
- Preventive benefits
- Health equity officers

Patient & provider diversity
- COCCI
- ABGH

Work with consumer-facing partners

Retail health
- Walmart, Amazon, Walgreens, CVS, etc.
- Provide key preventive health services
- Expand Flu/FT model
- Identify high risk patients

Transportation Apps
- Uber/Lyft
- Collaborate on transportation
- Key barrier to care

Activate patients & providers

Patients
Grassroots campaign to reach black patients and underserved populations

Endoscopists
Work with pilot project coordinators and navigators to provide colonoscopy for positive non-invasive tests
It takes a village

Education + Access + Navigation = \( \uparrow \) Adherence
Thank You!
Work Toward a HEDIS Measure

Thursday, November 17, 11:00 AM
CRC follow-up screening measure

Elizabeth L. Ciemins, PhD, MPH, MA

National Colorectal Cancer Roundtable Meeting
November 17, 2022
Presentation Outline

• AMGA overview
• Measure specification
• Measure exploration
• Reliability testing
• Feasibility testing
• Face validity and qualitative insights
• Future directions
AMGA: What we do

+ T2DM  Obesity  Immunizations  HTN  ASCVD

Between Groups
# < 3.5 = Weak
# 3.5 to 4.0 = Moderate
# > 4.0 = Strong
Integrating Evidence
Studying methods for integrating evidence-based practice into routine health care

Fostering Innovation
Discovering innovations originating in clinics that are responding to real-world challenges

Driving Change
Uncovering hidden meanings in data and the reasons driving behavior and process changes

More information at: research@amga.org
https://www.amga.org/performance-improvement/best-practices/research-analytics/
AMGA Membership

15% of AMGA members
25% of patients

OptumLabs participants
Other AMGA members
Representative AMGA Members
Measure Development Project
Advisors

- **Mary Barton**, MD, Vice President, NCQA
- **Frank Colangelo**, MD, MS-HQS, FACP, Director, Outcomes Office, Allegheny Health Network; CQO, Premier Medical Associates, National Colorectal Cancer Roundtable
- **Robert Smith**, PhD, Sr. Vice President for Cancer Screening, American Cancer Society
- **Richard Wender**, MD, Chair Family Medicine and Community Health at University of Pennsylvania School of Medicine
Objective

To develop and test a *Colorectal Cancer (CRC) Screening Follow-Up Measure* that measures the receipt of timely follow-up with a colonoscopy after a positive stool-based screening test (fecal immunochemical test (FIT) or multitarget stool DNA test (mt-sDNA)) for colorectal cancer.
Current HEDIS Measure

Assesses adults 45–75 who had appropriate screening for CRC with any of the following tests:

• fecal immunochemical test (FIT) (annually);
• FIT + multi-target stool DNA (mt-sDNA) (past 3 years);
• computed tomographic colonography (past 5 years);
• flexible sigmoidoscopy (past 5 years); and
• colonoscopy (past 10 years).
Measure: Colorectal Cancer Screening Follow Up within 6 months after Positive Stool-based Test (SBT)

Positive SBT (index) (eligible patients)

Follow-up colonoscopies (measurement period)

1/1/2018  7/1/2018  1/1/2019  7/1/2019

- Index positive SBT (denominator)
- Numerator compliant (measurement period)
Measure description

• The percentage of adults ages 45 through 75 who receive a diagnostic colonoscopy within 180 days following a positive stool-based screening test (SBT) for colorectal cancer (CRC) within the eligibility year.

• For the purposes of measure testing based on the available data (2016–2020), we will follow 2016 guidelines and test the quality measure among adults ages 50-75.
Measure testing population
Description of data

• Data for this study was obtained from the Optum Labs Data Warehouse, a database* of de-identified healthcare claims, clinical, demographic and other data elements

• De-identified EHR data (including outbound billing claims) sourced from 38 health care organizations (HCOs)
  – May not include treatment, i.e., colonoscopy, performed outside the contributing HCO (8.6% difference in sub-analysis)

*Study data were accessed using techniques compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and, because this study involved analysis of pre-existing, de-identified data, it was exempt from Institutional Review Board approval
Exclusion criteria

- Age <50 years
- History of malignant CRC diagnosis, total colectomy, or hospice care*
- To isolate “screening” population by eliminating presumed diagnostic SBT:
  - Hospitalization or ER visit within 14 days of a positive test
  - Diagnostic SBT per CPT code within 3 days prior to positive test result

*based on HEDIS measure
Attrition table for exclusion criteria

- Approximately 46% of the initial cohort did not meet the inclusion criteria
- 114,729 patients comprised the analytic cohort
  - 20,581 patients in 2018 eligibility year
## Table 1. Patient characteristics, 2018 (n = 20,581)

<table>
<thead>
<tr>
<th>Index age (Mean, (SD))</th>
<th>63.6 (7.1)</th>
<th>Insurance type (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex, Male (%)</td>
<td>10,009 (48.6)</td>
<td>Commercial 13,138 (63.8)</td>
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<tr>
<td>Race (%)</td>
<td></td>
<td>Medicare 1,056 (5.1)</td>
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<tr>
<td>African American</td>
<td>1,492 (7.2)</td>
<td>Medicaid 4,733 (23.0)</td>
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<tr>
<td>Asian</td>
<td>307 (1.5)</td>
<td>Other or Unknown 1,654 (8.0)</td>
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<tr>
<td>Caucasian</td>
<td>17,705 (86.0)</td>
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<tr>
<td>Other/Unknown</td>
<td>1,077 (5.2)</td>
<td>Metro UA 2,069 (10.1)</td>
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<tr>
<td>Ethnicity (%)</td>
<td></td>
<td>Large UC 165 (0.8)</td>
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<tr>
<td>Hispanic</td>
<td>644 (3.4)</td>
<td>Small UC 86 (0.4)</td>
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<tr>
<td>Not Hispanic</td>
<td>18,612 (90.4)</td>
<td>Rural 45 (0.2)</td>
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<tr>
<td>Unknown</td>
<td>1,325 (6.4)</td>
<td>Unknown 18,216 (88.5)</td>
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<tr>
<td>Education (%)</td>
<td></td>
<td>Smoking status (%)</td>
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<tr>
<td>High School Diploma or less</td>
<td>1,932 (9.4)</td>
<td>Never smoked 6,692 (32.5)</td>
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<tr>
<td>Associates or Bachelors</td>
<td>3,858 (18.7)</td>
<td>Not currently smoking 1,235 (6.0)</td>
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<td>Higher than Bachelors</td>
<td>712 (3.5)</td>
<td>Previously smoked 6,019 (29.2)</td>
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<tr>
<td>Unknown</td>
<td>14,079 (68.4)</td>
<td>Current smoker 3,763 (18.3)</td>
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<td>Household income (%)</td>
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<td>Charlson index (%)</td>
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<tr>
<td>&lt;$40,000</td>
<td>1,156 (5.6)</td>
<td>0 11,423 (55.5)</td>
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<td>$40,000-$74,999</td>
<td>1,482 (7.2)</td>
<td>1-2 5,900 (28.7)</td>
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<td>$75,000-$124,999</td>
<td>1,595 (7.7)</td>
<td>3-4 1,687 (8.2)</td>
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<tr>
<td>$125,000-$199,999</td>
<td>606 (2.9)</td>
<td>5+ 778 (3.8)</td>
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<tr>
<td>$200,000+</td>
<td>263 (1.3)</td>
<td>Unknown 792 (3.9)</td>
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Measure performance: percentage of patients with positive SBT who received a colonoscopy within 180 days
Measure performance, 2018 (n=38 HCOs)

Measure: percentage of patients with positive SBT who received a colonoscopy within 180 days

Median: 48%, Range: 13% - 67%
Measure performance over time, overall

![Graph showing performance over time](image-url)

- 2016: 36.5%
- 2017: 42.3%
- 2018: 47.2%
- 2019: 48.6%
- 2020: 42.6%
Performance over time, by HCO

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Performance over time, by race
Performance over time, by ethnicity
Performance over time, by age
Measure evaluation
Evaluation

• Sensitivity analysis
• Reliability testing
• Feasibility testing
• Face validity
Sensitivity Analysis

Absolute difference in follow-up colonoscopy rates between 90 vs 180 days (2018) (n=38)

• 90-day follow-up:
  • Mean: 36%
  • Median: 40%
  • Min: 8%
  • Max: 54%

• 180-day follow up:
  • Mean: 44%
  • Median: 48%
  • Min: 13%
  • Max: 67%

Proportion of follow-up colonoscopies across 38 HCOs, 2018:

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Reliability testing

• Signal-to-noise testing
  – Methods
    • Beta-binomial model
    • By healthcare organization, race, measurement year
  – Formula

Between-group variance

Between-group variance + group-specific or sampling/measurement error

– Good reliability:
  • 90% for individuals
  • 70–80% for groups
## Reliability testing: Results

<table>
<thead>
<tr>
<th></th>
<th>Race (mean)</th>
<th>Year (mean)</th>
<th>Year (mean)</th>
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<tbody>
<tr>
<td>Black</td>
<td>98%</td>
<td>2016</td>
<td>99.2%</td>
</tr>
<tr>
<td>Asian</td>
<td>95%</td>
<td>2017</td>
<td>99.3%</td>
</tr>
<tr>
<td>White</td>
<td>99%</td>
<td>2018</td>
<td>99.4%</td>
</tr>
<tr>
<td>Other</td>
<td>98%</td>
<td>2019</td>
<td>99.4%</td>
</tr>
<tr>
<td>Ethnicity (mean)</td>
<td>98%</td>
<td>2020</td>
<td>99.2%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>97%</td>
<td>HCO (mean)</td>
<td>96%*</td>
</tr>
<tr>
<td>Non-Hisp.</td>
<td>99.8%</td>
<td>Range: 88–99%</td>
<td></td>
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</table>

*Interpretation: 96% of variance in the measure was due to between-system differences*
Feasibility testing

- Three health systems conducted feasibility assessment
  - Evaluated data elements
    - Data Availability – data readily available in a structured format
    - Data Accuracy – data element >90% accurate under normal conditions
    - Data Standards – data element coded using nationally accepted terminology standard, e.g., CPT, HCPC, LOINC, etc.
    - Workflow – data captured during the routine course of care; how is workflow impacted?
## Feasibility testing: data elements

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<tr>
<th>#</th>
<th>Data Element</th>
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<tr>
<td>1</td>
<td>Patient age</td>
</tr>
<tr>
<td>2</td>
<td>Date and result of CRC screening SBT</td>
</tr>
<tr>
<td>3</td>
<td>Encounter: Identification of prior CRC diagnosis</td>
</tr>
<tr>
<td>4</td>
<td>Encounter: Identification of prior total colectomy</td>
</tr>
<tr>
<td>5</td>
<td>Encounter: Initiation of hospice or palliative care within 12 months of positive</td>
</tr>
<tr>
<td>6</td>
<td>Encounter: Identification of inpatient visit within 14 days of positive SBT</td>
</tr>
<tr>
<td>7</td>
<td>Encounter: Identification of ER visit within 14 days of positive SBT</td>
</tr>
<tr>
<td>8</td>
<td>Follow-up colonoscopy date</td>
</tr>
<tr>
<td>9</td>
<td>Race</td>
</tr>
<tr>
<td>10</td>
<td>Ethnicity</td>
</tr>
</tbody>
</table>
# Feasibility testing: partial results

<table>
<thead>
<tr>
<th>Data Element</th>
<th>EHR #1</th>
<th>Allscripts Touchworks version 20.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DATA AVAILABILITY</td>
<td>DATA ACCURACY</td>
</tr>
<tr>
<td>Patient age</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Data and result of CRC screening SET</td>
<td>1</td>
<td>1</td>
</tr>
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<tr>
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</tr>
<tr>
<td>Encounter: Initiation of hospice or palliative care within 12 months of positive SBT</td>
<td>1</td>
<td>0</td>
</tr>
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</tr>
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<td>Race</td>
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</tr>
<tr>
<td>Ethnicity</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**SUMMARY**

| Data Elements Scoring 0 within Domain | 2      | 3 | 2 | 2 |
| Total data elements                  | 10     | 10| 10| 10|
| % of data elements requiring review within domain | 20% | 30% | 20% | 20% |
## Feasibility testing: partial results

<table>
<thead>
<tr>
<th></th>
<th>Encounter: Initiation of hospice or palliative care within 12 months of positive SBT</th>
<th>data can be entered with a date and ICD-10 code but this is not captured &gt;90% of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Encounter: Identification of inpatient visit within 14 days of positive SBT</td>
<td>inpatient stays are on different EHRs from different orgs; CCDAs are received but are not structured/searchable data</td>
</tr>
<tr>
<td>6</td>
<td>Encounter: Identification of ER visit within 14 days of positive SBT</td>
<td>ER visits are on different EHRs from different orgs; CCDAs are received but are not structured/searchable data</td>
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</tbody>
</table>
Face Validity and Qualitative Insights
Qualitative Theme 1

Lack of knowledge about failure to follow-up
All providers expressed surprise at the low follow-up rates.

“Until we had this conversation, I assumed [the follow-up rate] was 100%.”
Qualitative Theme 2

Patient hesitancy around colonoscopy

- Not all patients are willing to have a follow-up colonoscopy even after a positive test.
- Discomfort with the colonoscopy preparation and procedure as a main concern of patients.
- Cost: follow-up colonoscopies after a SBT may be billed at a higher rate, or not covered (prior to 2021 change).

“Something as simple as the prep [for a colonoscopy] makes a big difference to patients. That’s the biggest thing that patients don’t want to go through”
Qualitative Theme 3

Trust and communication
Potential need for follow-up is regularly discussed at the time of ordering stool-based tests. Discussions with patients are the biggest facilitator to completing follow-up.

“As a provider, they trust you and your recommendations”
Facilitators and barriers

Facilitators of follow-up
• Integration with EHR
• Transparent reporting
• Ease of referral
• Dedicated staff
• Anticipatory guidance

Barriers to follow-up
• Lack of integrated gastroenterology
• Breakdown in communication of results, follow-up scheduling
• No typical “process”

“I think sharing data is excellent, I wish we were doing more”
Summary

• The CRC follow up measure meets the criteria for a quality performance measure submitted by health systems:
  – Variation in measure performance
  – Reliable
  – Feasible
    • May need to simplify exclusion criteria by removing inpatient and ED visit with SBT requirement
  – Face validity
Questions & Discussion
Thank You!
Q&A
Thank You!

nccrt.org  #NCCRT2022  @NCCRTnews  #80inEveryCommunity