American Cancer Society | NATIONAL COLORECTAL CANCER ROUNDTABLE | 80% IN EVERY COMMUNITY

2023 Steps for Increasing Colorectal Cancer Screening Rates:

A Manual for Primary Care Practices

CASE STUDIES

10 EXEMPLARY PRIMARY CARE PRACTICE CASE STUDIES

In the United States, colorectal cancer (CRC) is the third most commonly diagnosed cancer and the third most common cause of cancer-related death in both men and women. There are multiple screening options for CRC that can reduce this burden and save lives, however, more than one in three adults aged 45 and older are not up to date with recommended CRC screening (CRC Facts & Figures, American Cancer Society, 2023).

To address this gap and the 2018 change in the American Cancer Society's (ACS) CRC screening guidelines to recommend screening for average-risk patients at age 45, the ACS National Colorectal Cancer Roundtable (ACS NCCRT) published an update to the ***Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Primary Care Practices*** in 2022. To augment the updated *Steps Guide*, in the summer of 2021, the ACS NCCRT reached out to ten diverse primary care health systems that had made achievements in increasing their CRC screening rates. The following ten case studies are based on interviews conducted to assess these health systems' key innovations and strategies implemented in their specific populations as well as lessons learned.* Much of the content is in their own words and the ACS NCCRT thanks them for sharing their stories.

The goal of the *Steps Guide* and these case studies is to provide practical approaches and guidance for primary care practices to apply these interventions as part of a comprehensive approach to increase CRC screening. The summary chart on the following page provides high-level details for each health system and links to their in-depth summary. Within the summaries, example resources are linked and in the appendices.

*Many of the interventions documented were conducted before most health systems began implementing CRC screening for average risk patients at age 45, earlier than the previous recommendation to begin screening at age 50.

For questions or concerns, please reach out to the ACS NCCRT team at **nccrt@cancer.org**.

Sources:

American Cancer Society, 2023. Colorectal Cancer Facts and Figures. Accessed on 6/5/2023 from **https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/colorectal-cancer-facts-and-figures/colorectal-cancer-facts-and-figures-2023.pdf**

SUMMARY OF HEALTH CENTER INITIATIVES (CASE STUDIES)

Patient Strategies

- Patient reminder or recall/in reach
- Patient education
- Reducing client out-of-pocket costs
- Small media
- Navigator/Community Health Worker
- Automated campaigns
- Patient incentives

Clinician/Staff Strategies

- Provider assessment & feedback
- Provider reminder or recall
- Provider education
- Provider incentives
- Care team/team-based approach
- Clinical champion
- HIT interventions dashboard
- Shared decision-making model
- Standing orders
- Follow up to abnormal (positive) FIT

Reducing Structural Barriers

- Mailed FIT
- Transportation
- Community outreach
- Open scheduling
- Expanded office hours

Organization	Overview	Pg
Allegheny Health Network Premier Medical Associates *Pittsburgh, PA*	■ Large Multi-specialty Physician Practice ■ Urban ■ EHR: Allscripts	5
Coal Country Community Health Center *Beulah, ND*	■ Federally Qualified Health Center ■ Rural ■ EHR: Epic	9
East Boston Neighborhood Health Center *Boston, MA*	■ Federally Qualified Health Center ■ Urban ■ EHR: Epic	13
Family and Medical Counseling Service, Inc. *Washington, D.C.*	■ Federally Qualified Health Center ■ Urban ■ EHR: eClinicalWorks	16

CASE STUDY SPOTLIGHT

Allegheny Health Network
Premier Medical Associates

Type
Primary Care System

Location
Pittsburgh, PA

EHR
Allscripts

81,000+
patients

- 0.2% are best served in a language other than English
- 11% Black
- 0.8% (679 patients) Hispanic
- 1% (1,026 patients) of patients are uninsured

100+
providers

24
medical services and specialties

10
locations

Patient Strategies

- Patient reminder or recall/in reach
- Patient education
- Small media
- Navigator/Community Health Worker
- Automated campaigns

Clinician/Staff Strategies

- Provider assessment & feedback
- Provider reminder or recall
- Provider education
- Care team/team-based approach
- Clinical champion
- HIT interventions Dashboard
- Shared decision-making model
- Follow up to abnormal (positive) FIT

Reducing Structural Barriers

- Mailed FIT

Background

Premier Medical Associates, an affiliate of the Allegheny Health Network (AHN), is the largest multi-specialty physician practice in the Greater Pittsburgh area. In 2012, AHN had a colorectal cancer (CRC) screening rate of 57.5% with a 15-20% mailed fecal immunochemical test (FIT) kit return rate. Many providers were only offering colonoscopies as well, believing them to be the "gold standard" of CRC screening.

Results

Within 15 months of implementing changes, the practice increased its CRC screening rate to 75%. By 2019, AHN increased CRC screening rates to 88.7% through a combination of strategies, including a revised FIT kit mailing process (achieving a 90% mailed return rate) as well as the practice's efforts to follow up with patients with positive (abnormal) FIT results, AHN.

Evidence-based Strategies and Innovations

AHN used a multipronged approach to increase CRC screening rates, including patient- and clinician/staff-focused strategies as well as reducing structural barriers through their revised mailed FIT program. Patient and provider education as well as reminders for both groups, a shared decision-making model, provider assessment and feedback, a FIT registry, and follow-up on positive abnormal test results are highlights from their success story.

In 2012, Dr. Francis Colangelo, the chief quality officer at the time, acting as a provider champion, brought in a nationally recognized clinical champion to educate providers on the importance of offering patients appropriate choices for screening. By sharing data on practice performance and developing routine processes for outreach, mailing and follow-up, the organization implemented a mailed FIT intervention with high rates of success. AHN provided the following strategies to increase CRC screening rates as well as lessons learned:

Educate Providers to Offer Patients Choice

In 2012, Dr. Colangelo invited Dr. Richard Wender, ACS NCCRT chair at the time, to conduct grand rounds with 100 providers in the practice explaining the different screening modalities and the importance of offering patients choice in screening. They offered providers a new verbal script to use when offering patients CRC screening and explained the absolute need for the follow-up colonoscopy after positive or abnormal FIT results. Dr. Colangelo continues to be the clinical champion for this effort and continues to provide regular training to providers on offering patients choice. Examples of the scripts used to reinforce the need for colonoscopy after positive or abnormal FIT results are available in **Appendix CS01-1**.

Be Transparent in Reporting Data

The practice began to transparently report monthly CRC screening rates in a visual display at provider meetings, listing each provider and how well their patient panel was doing on meeting the metric. The practice has transitioned to reporting CRC screening rates by office location instead of by provider, emphasizing the team-based nature of the improvement initiative. Examples of the current report of screening rates by office location and original provider-by-provider CRC Screening dashboard display are included as an attachment to this case study.

Outreach to Existing Patients Turning 50* Each Month

Each month, the quality team pulls lists of average-risk patients who are newly turning 50 in the upcoming month (an average of 50-70 patients per month) and sends a tailored phone message about screening. The message alerts the patient that it is time to begin screening, that there are multiple ways for the individual to get screened, and that a kit will be mailed to their house that week for them to start screening. These patients are then added to the practice's FIT Registry for annual FIT screening. Increased or high-risk patients receive a recommendation to go straight to colonoscopy. The practice is now implementing plans to include patients aged 45-50 who have not been screened in such outreach.

* At the time this intervention was conducted, most major guidelines recommended individuals at average risk of CRC start screening at age 50.

FIT Registry

The organization maintains a FIT registry within an Excel spreadsheet of all average-risk patients who have reached the initial age of screening and who choose to be screened with FIT, and on the 11-month anniversary of their prior test, the health center mails a FIT kit to them. Most of the patients return their FITs within a week or two. The registry contains nine years of data for patients whom they've been following for eight years now, and that's what has enabled the practice to achieve screening rates above 80% and to keep them above 80%. Patients who have a positive or abnormal FIT result are moved into the practice's Abnormal FIT Registry (see below).

Abnormal FIT Registry

For patients who have a positive or abnormal finding on a FIT, the practice added an Alert to the EHR banner indicating "+FIT Test" in red text to grab the attention of the provider and address the issue. Providers offer these patients colonoscopy scheduling and follow-up with these patients every six months until the colonoscopy is completed. Once a colonoscopy is completed, patients are followed-up for colonoscopy screening at the recommended interval for their level of risk.

Automated Robocall Reminders

The health system quality department runs monthly automated robocall campaigns just prior to the kits being mailed to patients. The calls are run via their EHR which delivers a recorded message to patients reminding them that their screening anniversary is coming up and that they'll be receiving a FIT kit in the mail from the health system. The quality team then mails out the FIT kits to all patients who are due for their screening that month.

Exam Room Screening Reminder Posters

Every exam room has a locally created poster that provides education on the importance of CRC screening. An example poster is included as an attachment to this case study in **Appendix CS01-2**.

Educating Providers on Timely Follow-up of Abnormal FIT Results

The practice makes an ongoing, concerted effort to remind providers that all positive or abnormal screening tests must be followed by colonoscopy. Examples of the scripts made available to providers are included in **Appendix CS01-1**.

Messaging to Patients About Abnormal FIT Results

The practice provides the medical assistants and RNs with a script to use for patients who receive positive or abnormal FIT results and are reluctant to proceed with colonoscopy. Patients are reminded every 30 days to schedule their follow-up colonoscopy if necessary. Patients who still don't schedule the colonoscopy receive a mailed letter from their provider outlining the potential negative consequences of delaying follow-up.

Tools Shared

- Examples of:
  - Script for providers for FIT – **Appendix CS01-1**.
  - Script used by MAs/RNs when contacting patients who had positive or abnormal FIT results and are reluctant to proceed with colonoscopy – **Appendix CS01-1**.
  - Mailed letter for monthly positive or abnormal FIT/colonoscopy procrastinators – **Appendix CS01-1**.
  - Robocall/text (sent one month before 50th birthday if patient has never been screened before) – **Appendix CS01-1**.
  - Example of provider-by-provider CRC screening dashboard display – **Appendix CS01-3**.
  - Screenshots of Abnormal FIT Alert in EHR and Abnormal FIT Registry – **Appendix CS01-4**.
- Exam Room Poster – **Appendix CS01-2**.

Interviewee

Frank Colangelo, MD, MS-HQS, FACP
Vice President and Chief Quality Officer
Premier Medical Associates

CASE STUDY SPOTLIGHT

Coal Country Community Health Center

Type
Federally Qualified Health Center

Location
Beulah, ND

EHR
Epic

8,685
patients

4
locations

- 28.4% of patients at or below 200% Federal Poverty Guideline
- 0.5% of patients are best served in a language other than English
- 8.1% of patients are uninsured

Patient Strategies

- Patient reminder or recall/in reach
- Patient education
- Small media
- Navigator/Community Health Worker

Clinician/Staff Strategies

- Provider reminder or recall
- Care team/team-based approach
- Clinical champion
- HIT interventions dashboard
- Shared decision-making model
- Follow up to abnormal (positive) FIT

Reducing Structural Barriers

- Transportation
- Community outreach
- Expanded office hours

Background

Coal Country Community Health Center (CCCHC) provides colorectal cancer (CRC) screenings for patients in rural and remote areas. These patients have unique challenges and access issues and in 2012, CCCHC had a CRC screening rate of 29%.

Results

By January 2018, CCCHC had increased its CRC screening rate to 68% through the implementation of several innovative quality improvement projects. Their 2019 screening rate dipped to 56% but increased to 59% in 2020 despite challenges posed by the COVID-19 pandemic.

Evidence-Based Strategies and Innovations

CCCHC saw opportunities to strengthen its collaborative relationship with the local critical access hospital and tertiary hospitals to increase screening rates, as well as make improvements to their own internal CRC screening process. For patients, they focused on education, reminders, small media, and navigation. With a clinical champion, they created a team-based approach, dashboards, reminders, shared decision-making, and improved process on follow-up after a positive or abnormal fecal immunochemical test (FIT). Lastly, they conducted community outreach, provided transportation to appointments, and expanded office hours to reduce structural barriers.

Furthermore, under the direction of Dr. Aaron Garman, Medical Director, the health center's healthcare delivery transformed from an acute care model, where they focused on sick visits, to a prevention and wellness model, where they are proactively working to keep their patients well. CCCHC shared the following solutions and lessons learned from their CRC screening interventions:

Distributing FIT

The health center provides FITs to patients while they are in the practice. Patients are then able to return kits to the health center in-person or by mail.

Referrals and Preferred Partnerships

- The health center has a strong relationship with the local critical access hospital in the area, which allows them to schedule colonoscopies relatively easily and have a seamless process for closing the referral loop. The critical access hospital has their own surgeon on staff, and the health center has a clinic in it. Before the patient leaves for the visit, they will have their colonoscopy appointment scheduled with the local critical access hospital.
- The health center also has an established relationship with each of the two tertiary hospitals about 80 miles away for patients who prefer to travel to one of the two facilities.
- The health center utilizes the same EHR as the critical access hospital and both tertiary hospitals, making it easy to share patient records.
- Incomplete referrals are sent from the medical records team to the nurse to perform follow-up. The reason is then documented in the EHR as to why the colonoscopy was not completed, canceled, or rescheduled.

Existing Patient Outreach

The health center does a 100% recall for all patients who are not up to date on their CRC screening every six months. Quarterly reminders are also sent through the patient portal automatically for preventive screenings.

Historical Test Result Data

When reviewing the medical record to see if a patient has completed their screening, any missing historical test records are requested from the entity that performed the screening. Once the historical results have been received, the medical records department sends the historical results to the nurse to update the medical record.

EHR-based Best Practice Advisories

Within the EHR there are best practice advisories to guide the providers to perform preventive screenings. The health center can also submit requests to the EHR vendor to customize these alerts. The practice also uses order sets customized to the type of screening ordered.

Three-Step Recall Process

The health center utilizes the dashboards within the EHR.

- When an order is noted as delinquent in the EHR, the health center first mails a letter to the patient. The practice then contacts the patient via phone if the screening has not been completed within two weeks, then lastly the practice sends another letter.
- The health center also uses text messages for reminders.
- Reminders are also sent through the patient portal via the EHR.

Patient Education

- The health center uses the patient education module within the EHR to print education for patients. The practice also works with the North Dakota Colorectal Cancer Roundtable to develop messages and education for patients. Additionally, the health center works with other health centers and the state primary care associations in North and South Dakota to share patient education resources for CRC screenings.
- The health center provides services and education through numerous community health fairs.
- The health center uses social media platforms to provide education to the community.

Structural Barriers

- The health center provides transportation services for patients to their practice. The practice and the critical care access hospital are working jointly to overcome patients' transportation barriers for colonoscopies.
- The health center provides after-hours services for patients unable to come between 8am–5pm.

Outreach and Follow-up

- The health center uses a team-based approach with RN care coordinators to assist with closing loops and gaps in care.
- The day before the visit the care coordinator performs pre-visit planning and reviews the charts for any gaps in care. If any gaps are noted, it is communicated to the patient's care team via "huddle notes" within the EHR.
- During the visit, the care team reviews and provides the FIT if appropriate, along with education on how to complete the screening.
  - For normal FIT results, a letter is sent to the patient or a message is sent through the patient portal. All normal/negative results are automatically published to the patient portal.
  - The health center follows up with patients immediately upon receiving positive or abnormal FIT results. The patient is contacted by the nurse via phone and the care team determines if the patient must come in for a follow-up appointment. If the health center has been unsuccessful in reaching the patient by phone, a certified letter is mailed to the patient.
  - Kits that have not been returned are identified within the EHR as orders without results, and the nursing staff follows up. Positive or abnormal results are flagged to the provider and are scheduled for a follow-up appointment.
- If a colonoscopy is the appropriate screening method, the provider performs the history and physical at that visit to prevent the patient from having to return for another visit. The appointment is made for the patient's colonoscopy and the bowel prep instructions are given to the patient at that visit. A staff member from the critical access hospital performs a reminder call the day before the scheduled colonoscopy to review steps with the patient. After the colonoscopy, the results are sent back to the health center with the recommended screening frequency, the reason for increased screening frequency, and the health maintenance module within the EHR is updated.

Navigation for Patients with Positive or Abnormal Results

The care coordinator for each care team navigates patients with positive or abnormal results. The care coordinator is also responsible for updating the patient's medical record if information was received by an interface, and the provider signs off on it.

Interviewee

Chastity Dolbec, BSN, RN
Director of Patient Care and Innovation
Coal Country Community Health Center

CASE STUDY SPOTLIGHT

East Boston Neighborhood Health Center (EBNHC)

EAST BOSTON NEIGHBORHOOD HEALTH CENTER

Type
Federally Qualified Health Center

Location
Boston, MA

EHR
Epic

80,744
patients

- 87.5% of patients at or below 200% Federal Poverty Guideline
- 61.2% of patients are best served in a language other than English
- 20.6% of patients are uninsured

Patient Strategies

- Patient education
- Small media
- Patient incentives

Clinician/Staff Strategies

- Provider reminder or recall
- HIT interventions dashboard

Background

In 2017, East Boston Neighborhood Health Center (EBNHC) set a goal to increase its colorectal cancer (CRC) screening rate from a baseline of 38.1%. Then, at the beginning of 2021, EBNHC also prioritized low rates of returned or successfully completed stool-based CRC screening tests (as many as 20% of returned tests had “inadequate” or “incomplete” results).

Results

As a result of changes EBNHC increased their UDS CRC screening rate by more than 20 percentage points to 58.5% by 2019. Further work to improve fecal immunochemical test (FIT) completion reduced returned inadequate or incomplete tests from a rate of 20% in February 2021 to 11% by April 2021.

Evidence-based Strategies and Innovations

To raise CRC screening rates, EBNHC used multiple strategies focused on patients and providers. They credit customization of patient education and patient incentives for FIT return as one part of their success story. Additionally, they achieved success by implementing provider reminders, a dashboard, and a health intervention technology (HIT) intervention to increase rates. EBNHC shared the following solutions and lessons learned from their CRC screening interventions:

Educational Materials

EBNHC developed patient-friendly educational materials, including YouTube videos in English and Spanish and FIT instructions, such as step-by-step pictorial diagrams. QR codes that link to educational materials are also provided to patients in after-visit care summaries.

Patient Incentives

The health center offers a $25 gift card raffle incentive to patients who return their completed FITs during the month of the raffle.

FIT Kit Customization

The health center customized FIT kits to make them more patient-friendly in the following ways:

- Removing the pen/paper order form provided by the lab company and applying the sticker with the unique order identification number to the FIT; part of the FIT workflow is that the medical assistant enters the order identification number for the card into the electronic order when ordering the test.
- Inserting pictorial instructions along with QR Codes and links to patient instructional videos in English and Spanish.
- Inserting an incentive flyer on how to enter the raffle for a $25 gift card for returning completed kits to the lab during the month of the raffle.

Patient Reminders

EBNHC created provider alerts within Epic Storyboard.

HIT/Dashboard

- Created one-click pathway within Epic for ease of use for providers.
- Created report within EHR showing inadequate/incomplete tests using specified fields.

Tools Shared

- Patient pictorial instruction sheet with QR codes to access the patient videos on YouTube – **Appendix CS03-1**.
- Incentive flyer – **Appendix CS03-2**.
- Listing of fields used from EHR to report on inadequate/incomplete tests – **Appendix CS03-3**.
- Screenshots of Provider Alert in Epic Storyboard and sample one-click order for FITs – **Appendix CS03-04**.
- Screenshot of after-visit summary from a test patient portal account that includes patient instructions for FITs – **Appendix CS03-5**.

Interviewees

Karin Leschly, MD
Medical Director
East Boston Neighborhood Health Center

Heidi Emerson, PhD, MPH
Quality Improvement and Population Health Manager
East Boston Neighborhood Health Center

CASE STUDY SPOTLIGHT

Family and Medical Counseling Service (FMCS)

Type
Federally Qualified Health Center

Location
Washington, D.C.

EHR
eClinicalWorks

3,362
patients

- 81.5% of patients at or below 200% Federal Poverty Guideline
- 1.3% of patients are best served in a language other than English
- 24.0% of patients are uninsured

Patient Strategies

- Patient reminder or recall/in reach
- Patient education
- Small media
- Navigator/Community Health Worker
- Automated campaigns

Clinician/Staff Strategies

- Provider assessment & feedback
- Provider reminder or recall
- Care team/team-based approach
- HIT interventions dashboard
- Follow up to abnormal (positive) FIT

Reducing Structural Barriers

- Mailed FIT
- Transportation

Background

In 2017, Family and Medical Counseling Service, Inc. (FMCS) had a colorectal cancer (CRC) screening rate of 34.6%. FMCS faced process and capacity challenges with CRC screenings due to not having a dedicated staff person to assist with these efforts, including follow-up with patients.

Results

By 2020, FMCS increased its CRC screening rate by 12 percentage points to 46.8%. The practice attributes its success in streamlining their processes to having a patient navigator dedicated to CRC screening efforts.

Evidence-based Strategies and Innovations

FMCS used multiple strategies to increase their CRC screening rate. To address structural barriers, they used funding from the DC Primary Care association to provide transportation as well as a mailed fecal immunochemical test (FIT) campaign. Clinicians and patients received reminders, and a team-based approach was used as well as dashboards and a streamlined process for follow-up after positive or abnormal FITs. A variety of patient education was provided too, but their biggest change was hiring and utilizing a patient navigator to assist with CRC screening. The practice shared the following solutions and lessons learned from their CRC screening interventions:

Patient Navigators Consistently Follow Through with Patients

- The practice hired a patient navigator to oversee CRC screening efforts. By having a dedicated patient navigator, the health center ensured consistent follow-through with patients for screening.
- The patient navigator provides education and instructions to patients on FIT kits and follows up with them to return the kits.

Mailed FIT: Postage Issues

During the pandemic, the practice experienced issues with inconsistent postage on FIT kits mailed to patients that made it difficult to fully implement a mailed FIT campaign. Of the FIT kits distributed by mail, approximately 60% of patients returned their testing kits.

Patient Screening Reminders

- The practice uses robo-calls through an automated system to provide reminder calls, texts, and emails for patients overdue for screening. These reminders continue until the screening is completed.
- After giving patients a FIT kit to take home, the navigator creates a “dummy” referral in the EHR and creates actions in the EHR to serve as reminders to follow up with patients to return the FIT kits.
- The practice schedules follow-up appointments with patients to return to the office within a couple of weeks and instructed patients to bring the completed kit with them for the return visit.
- When patients do not return the FITs during a return visit, providers receive notifications via telephone encounters and are encouraged to re-engage the patient at the next visit.

Positive or Abnormal Results Follow-up

The patient navigator flags the result in the system and sends it to the provider as high priority. The provider then calls the patient with the results and alerts the patient navigator if a follow-up colonoscopy is needed. The navigator follows up with the patient and states “I am following up on the results that were shared with you by your doctor”.

Colonoscopy Referral Follow-Through

- The patient navigator schedules the colonoscopy appointment for the patient. Two days before the appointment, the navigator conducts a reminder call. If transportation barriers are noted, the navigator works to set up transportation assistance. Once results are returned, they are attached to the order, and a note is entered in the referral/diagnostic imaging order stating, "the report is attached, please enter results". It is then assigned to the provider.
- If the patient does not show for their colonoscopy, the navigator tries to reach the patient three times. For those that remain unsuccessful, the navigator sends the order back to the provider, and in the results writes "scheduling unsuccessful".

Lab Requisitions

To prevent discrepancies with specimens and orders, the patient navigator staples the lab requisition form to the shipping envelope and instructs patients to include their name and date of birth on the kit.

Provider Prompts in the EHR

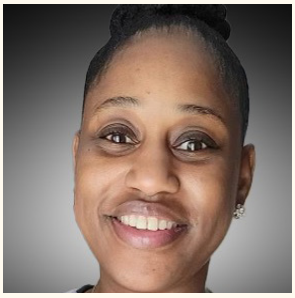
- **Clinical Decision Support System (CDSS) Alerts & Chart Reviews** – CDSS alerts providers and staff if the patient is due for a CRC screening. In addition, the medical assistants conduct chart reviews the day before the visit and will add a note if the patient is due for a screening.
- **Healthcare Effectiveness Data and Information Set (HEDIS) Dashboard** – allows providers to review their individual compliance rates with clinical quality measures. Providers can drill down to view which patients are non-compliant.
- Appropriately attaching results to diagnostic imaging orders is key for the practice to receive performance measure credit for performing the screening. The patient navigator worked to streamline this process and ensure that the proper dates were on the orders. This was a collaborative effort between the navigator, medical records, and medical assistants.

Patient Education

Prior to the COVID-19 pandemic, the patient navigator provided American Cancer Society (ACS) pamphlets to patients and performed face-to-face education. During March, Colorectal Cancer Awareness Month, FMCS also set up a table in the lobby to provide educational talks about CRC. The practice also provides patient education via the patient portal. If the patient navigator was not able to perform in-person education, they would provide education via phone and send an ACS pamphlet via mail.

Structural Barriers

- **Medical Transportation** – Through their partnership with the DC Primary Care Association, the health center received funds to assist some patients with transportation needs to consult appointments. Pre-COVID, the navigator also arranged for transportation for post-op procedures.
- **Courier** – The navigator sometimes picks up specimens directly from patients' homes.



Interviewees

Demetria A-T Premier, MSW
Quality Improvement Health Information Management Coordinator
Family and Medical Counseling Service, Inc.

Michael Serlin, MD
Former Medical Director
Family and Medical Counseling Service, Inc.

Marquita Iddirisu
Former Patient Navigator
Family and Medical Counseling Service, Inc.

CASE STUDY SPOTLIGHT

Mercy Health System

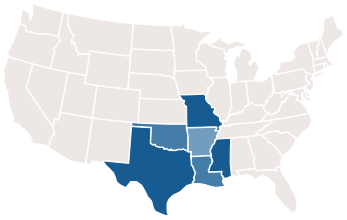
Type
Primary Care Practice

Headquarters
St. Louis, MO

EHR
Epic

3,671,033
outpatient visits in 2020

Practices in



Patient Strategies

- Patient reminder or recall/in reach
- Patient education
- Small media

Clinician/Staff Strategies

- Provider reminder or recall
- Provider education
- Provider incentives
- Care team/team-based approach
- HIT interventions dashboard
- Shared decision-making model

Reducing Structural Barriers

- Mailed FIT

Background

Mercy Health System (MHS) examined their colorectal cancer (CRC) screening process and calculated it would need to recruit 32 providers to conduct screening colonoscopies full-time just to address the backlog of colonoscopies. To alleviate this backlog, they implemented a policy of offering fecal immunochemical tests (FITs) as the first line of screening for average-risk patients in what they called their “FIT first” campaign.

Results

Eighty-five percent of MHS patients completed their CRC screening without needing a colonoscopy during the FIT first campaign. The cost savings and reduction in unnecessary burden on the health system were significant. By 2019, the health system had reached an overall CRC screening rate of 60% and increased that to 76% by 2021 among Medicare patients.

Evidence-based Strategies and Innovations

MHS has taken a patient-centered approach to CRC screening, engaging in shared decision-making, while also training staff and providers on how to provide options to the patients. Providers and care teams worked together and received reminders, used an HL7 interface (data processing system) upgrade, and implemented a mailed FIT campaign to increase CRC screening rates.

At the beginning of this process, MHS found that their practices considered FITs easy to dismiss due to the lack of upfront financial reward and the required follow-up after a positive or abnormal test. The COVID-19 pandemic created an opportunity for the health system to use FITs as an appropriate option for CRC screening when screening colonoscopies were paused and the subsequent backlog of patients needing screening ensued. MHS shared the following solutions and lessons learned from the changes they made to their CRC screening strategy:

Mailed FIT Kits

- Obtaining test results can be challenging when the intervention is led by a health system partner and not the practice. The health system partnered with a Medicare Advantage plan on a mailed FIT intervention where FIT kits were mailed directly by the health plan to beneficiaries, rather than distributed by providers to patients. The main challenge that the practice encountered with this intervention is that they were unable to successfully track and follow-up with patients at the system level on completion of the tests, results of the FITs, and follow-up of positive or abnormal results. While the health plan would send the results back to the primary care providers at the practice, there was often a lag of several months before the results were manually logged into the practice EHR. Since there was no mechanism to electronically transmit the results directly from the health plan to the practice EHR, the practice ran into challenges with reliably entering and tracking results. The health system found they require tighter control to ensure receipt of timely results to effectively follow-up with patients on their test results and ensure proper follow-up if needed.
- **Patient Education** – The FIT kit used by their lab (InSure® ONE™) is an at-home test kit that only requires water-based sampling of one bowel movement. The practice is currently going through the process of retooling and implementing new workflows for mailing these FIT kits and ensuring that patient education instructions are included in mailings to refer to the water-based method as opposed to their previous FIT that required the patient to also brush the stool.
- **"Freshness counts"** – The health system found it is necessary to ensure that specimens are sent to the lab before they expire and to be cognizant of expiration dates of test kits. Staff and providers need to communicate to patients the importance of timeliness in returning samples. If specimens are being sent or dropped off at the provider's office before being sent to the lab, they should be sent to the lab right away to ensure freshness. Labs will not process expired kits either.
    - Postal service issues – during the pandemic, it sometimes took two weeks or more for samples to reach the labs. If mailing specimens, they need to be sent as soon as possible since many samples expire within four to six weeks.

- Best practices/lessons learned:
  - Conduct pilot tests to work out potential kinks with mailed materials
  - Ensure return envelopes are pre-labeled and stamped with appropriate postage
  - Follow-up with patients should occur within a week of distributing test kits

EHR Point of Care (POC) Prompts

The Encounter Guide EHR POC prompt provides alerts used by roomers to begin educating patients and start the conversation about CRC screening. The health system uses patient educational content from Healthwise in the EHR, which can be made available to patients as a printed handout and/or transmitted electronically via the patient portal. FIT kits are provided either during the visit or mailed to the patient.

mt-sDNA (Cologuard) HL7 Interface

For patients whose health insurance covers Cologuard, the health system has a bi-directional interface with EPIC that enables them to order Cologuard and receive the results of the test through the interface. This has been a turnkey solution for the providers. Once the HL7 interface is established, the order gets sent directly to Exact Sciences (the maker of Cologuard) from the EHR, and Exact Sciences follows up with the patient. The resulting report comes back to the EHR electronically through the interface.

Provider Incentives

In July 2021, MHS began a compensation incentive tied to quality achievements, which includes CRC screening as one of those measures. Since they still have colonoscopy backlogs, they are using this opportunity to drive “FIT first”.

Provider/staff Education

MHS is now re-educating staff about the new FIT kit, realizing that the clinical teams, providers, and staff all need reassurance about test reliability and the differences in sample methodology. It is critical that patients hear consistent instructions from everyone that they interact within the health system.

FIT First

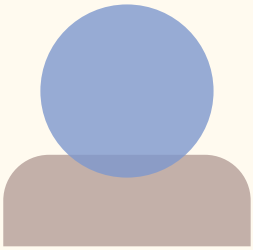
By leading with FITs first for average-risk patients and prioritizing patients with positive or abnormal results for colonoscopy, the health system is addressing what it sees as a myth of the reliability of testing options. The health system believes the message should be: “All tests are equally reliable if the tests are followed through” and still takes an informed and shared decision-making approach with patients. The health system also shares information with providers, called “Throw a FIT”, about cost-effectiveness of the stool-based tests to help reduce their bias towards colonoscopy for average risk patients.

Tools Shared

- Encounter Guide – during the rooming process, if the patient is due for CRC screening, a point of care prompt will come up for the provider in the EHR – **Appendix CS05-1**.
- Sample letters, sample script for campaigns, telephone and text messaging campaigns – **Appendix CS05-2**.
- Information on how to provide patient-centered, cost-effective CRC options to patients in making the decisions ("Throw a FIT" provider training slides) – **Appendix CS05-3**.

Interviewees

James Rogers, MD, FACP
Adult Primary Care and Medical Director
Mercy Health System



Debra Barnhart
Director of Operations
Mercy Health System

CASE STUDY SPOTLIGHT

NOELA Community Health Center – Mary Queen of Vietnam (MQVN) Community Development Corporation

Type
Federally Qualified Health Center

Location
New Orleans, LA

EHR
Athena Health

4,904
patients

- 94.0% of patients at or below 200% Federal Poverty Guideline
- 63.2% of patients are best served in a language other than English
- 36.0% of patients are uninsured

Patient Strategies

- Patient reminder or recall/in reach
- Patient education
- Small media
- Navigator/Community Health Worker

Clinician/Staff Strategies

- Provider assessment & feedback
- Provider reminder or recall
- Provider education
- Care team/team-based approach
- Clinical champion
- HIT interventions dashboard

Reducing Structural Barriers

- Mailed FIT

Background

NOELA's initial review of colorectal cancer (CRC) screening rates in 2013 revealed a rate of 3%, prompting them to make increasing CRC screening a priority. By 2014, NOELA started work with the American Cancer Society and signed the 80% by 2018 pledge (a commitment to strive toward reaching an 80% screening rate). In 2016, their rates had increased to 70.4% and they were working to further increase their rates.

Results

NOELA's UDS CRC screening rate increased to 80% in 2018, achieving the above-mentioned goal. In 2019 their rate was 73.4% and in 2020 it was 75.5%, remaining consistently high across time, including during the COVID-19 pandemic.

Evidence-based Strategies and Interventions

NOELA employed several different strategies to boost their already high CRC screening rates, including implementation of a mailed fecal immunochemical test (FIT) intervention, patient navigators educating patients about CRC screening, providing training to all staff on how to distribute FIT kits to patients, and use of provider dashboards to promote screening within the practice. NOELA provided the following solutions and lessons learned:

Share Data and Feedback with all Staff

The quality improvement director runs monthly reports on the health center's CRC screening data and conducts provider feedback sessions. During the sessions, the staff review test results and ensure that patients are receiving appropriate follow-up. They also look at missed opportunity reports to understand the number of patients that have completed CRC screening and those that have not, and then try to focus on how to improve their screening rates.

- **CRC data and reports shared with all staff:** cancer screening rates comparison (year-to-date); CRC screening – monthly comparison; CRC screening – trailing year comparison; CRC screening – missed opportunity report; colonoscopy vs. FIT.
- **Data and reports shared with patient navigators:** CRC screening trend report; care coordination – client reminders/patient navigation; FITs distributed vs. FITs returned; FITs distributed tracker.
- **Data and reports shared with providers:** daily huddle notes; provider scorecard; cancer screening provider comparison; data discussed during QI meetings.

Patient Navigators

- Navigators go through the registry of existing patients that are due for FIT and contact them by phone. If they have an upcoming appointment, the navigator informs the patient that during their upcoming appointment they can pick up an FIT kit.
- After distributing the FITs, the navigator calls the patient to remind them to bring back the test within a week or two of giving it out, and then reminds them monthly until the test is returned.
- NOELA found they have a better FIT return rate when the patient navigator distributes the FIT than when the provider gives it out. They found this had more to do with the follow up provided by the patient navigator handing it out as opposed to lack of a consistent follow up when the provider gives it out.

Mailed FITs

During the height of the COVID-19 pandemic, patients often didn't want to come into the health center. When reaching out to remind patients, navigators would ask if patients preferred to pick up or receive mailed FIT kits. If mailed a kit, patients would either return them in the mail or bring them back to the health center, as most do not live very far away.

Mail Postcards to Patients Who Don't Respond to Phone Calls

Reminder postcards are mailed to patients who are not available by phone, asking them to call to schedule an appointment. For patients reached by phone, if they are unable to come into the clinic, they're offered the opportunity to receive the FIT kit by mail.

Train Clinical and Non-clinical Staff to Communicate with Patients About FIT

NOELA trained most staff in the clinic on how the test is performed. Whether it's front desk staff or medical assistants, they all know how to explain the process to patients. If the medical assistant did not cover it with the patient by the time the provider gets in the room, the provider will make the recommendation and then either the provider will give the FIT kit to the patient, or at checkout, they ask the front desk staff to explain to patients how to complete it before they leave. Most of the staff are familiar with the test, how it's conducted, and how to explain it to patients.

More Visits per Year = Better Screening Percentage

NOELA found a strong correlation between the number of visits patients have per year, and whether they were up to date with their screenings or not. Patients who tend to complete the FIT kits are the ones who have at least three or more visits throughout the year.

Interviewee

Keith Winfrey, MD
Chief Medical Officer
New Orleans East Community Health Center

CASE STUDY SPOTLIGHT

North Hudson Community Action Corporation (NHCAC)

NORTH HUDSON COMMUNITY ACTION CORPORATION

Type
Federally Qualified Health Center

Location
Union City, NJ

EHR
eClinicalWorks

58,896
patients

- 96.6% of patients at or below 200% Federal Poverty Guideline
- 76.2% of patients are best served in a language other than English
- 46.3% of patients are uninsured

Patient Strategies

- Patient reminder or recall/in reach
- Patient education
- Reducing client out-of-pocket costs
- Navigator/Community Health Worker
- Automated campaigns

Clinician/Staff Strategies

- Care team/team-based approach
- Standing orders
- Follow up to abnormal (positive) FIT

Reducing Structural Barriers

- Mailed FIT
- Expanded office hours

Background

In 2017, North Hudson Community Action Corporation (NHCAC) had a colorectal cancer (CRC) screening rate above 71.4%, higher than the national average for FQHCs. They still prioritized reaching a CRC screening rate of 80% or higher in their clinics, which serve over 50,000 predominantly Hispanic/Latino patients.

Results

By 2018, NHCAC's UDS CRC screening rate increased to 87.1%. Like other health centers, the health center experienced a decline in their UDS CRC screening rates to 77.1% during the height of the COVID-19 pandemic in 2020. As of June 2021, the health center reported that their screening rate had started to improve again and was up to 82%.

Evidence-based Strategies and Innovations

NHCAC prioritized increasing CRC screening rates by continually improving screening processes and addressing patient barriers to screening, including hesitancy to complete CRC screening. They provided patient education as well as funding for screening costs if needed. A team-based approach, standing orders, expanded hours, and a mailed fecal immunochemical test (FIT) campaign were also used to increase rates. The health center shared the following key interventions they implemented, and lessons learned:

Outreach to Existing Patients/Patient Reminders

- A data analyst provides a list of patients reaching the initial age of screening in that year to patient navigators who conduct outreach to bring patients in for screening.
- The practice developed a Happy Birthday Letter to remind patients that they are due for CRC screening.

Standing Orders

Standing orders are available so medical assistants can order the test for eligible patients without waiting for an order from a primary care clinician.

Location of FIT/Guaiac-based Fecal Occult Blood Test (gFOBT)

Tests are kept in the clinical area for easy access. Medical assistants provide the education to the patients rather than the patients going to the lab.

Mailed FIT/gFOBT

- The practice mails FIT/gFOBT to patients during telehealth visits with specific instructions on how to return the test. Patients return tests to the practice in-person, they do not mail tests back.
- The practice was able to utilize some of the American Rescue Plan (ARP) COVID-19 funding to assist with implementation.

Test Affordability

For patients without health insurance who cannot afford a FIT, gFOBT is provided. The practice also offers charity care and the CDC-funded **NJ Cancer Education and Early Detection (NJCEED)** program provides free screenings to patients in need.

Patient Education and Communication

- Most non-compliance arises from patients not wanting to perform the test, so the practice relies upon patient education to address patients' reluctance to screening.
- The practice utilizes the EHR to send out reminder letters, texts, calls, and campaigns. Patient education is sent through the patient portal.

Team-based Approach

- Medical assistants perform chart scrubs the day before every patient visit. They also order the test where appropriate and educate the patient on the testing instructions.
- **Negative/normal FIT/gFOBT results** – once results are received, they're communicated to patients by the provider through the portal within two weeks.
- **Abnormal FIT/gFOBT results** – the provider signs off on any abnormal results within seven days with a plan of care and follow-up. The patient navigator reviews abnormal results and follows up with the patient.
- **Positive FIT/gFOBT results** – Patient navigators follow up with patients who have had positive results to schedule them for an appointment to review the results. Referral navigators follow up on referrals for patients for diagnostic colonoscopies. The referral navigators make appointments for the follow-up colonoscopy and assist patients with the process.

Extended Office Hours

The practice has office hours until 7 p.m. some days and also provides services on Saturdays. This allows patients to return kits outside of normal business hours.

Robo-calls

The practice uses an automated system to send robo-calls to patients overdue for returning lab tests.

Tool Shared

Sample Happy Birthday letter – in English and in Spanish

Interviewees

Rita Knause, MD
Chief Medical Officer
North Hudson Community Action Corporation

Jeannette Sujovolsky, DO
Director of Adult Medicine
North Hudson Community Action Corporation

Nishie Perez, MA, BSN, RN
Director QI/CRM, Medical Affairs Department
North Hudson Community Action Corporation

CASE STUDY SPOTLIGHT

Sanford Health

Type
Primary Care System

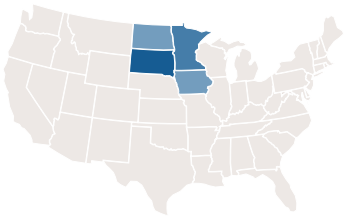
Headquarters
Bismarck, ND

EHR
Epic

5.2M
outpatient and clinic visits

40%
rural population

Practices in



Patient Strategies

- Patient reminder or recall/in reach
- Patient education
- Small media

Clinician/Staff Strategies

- Provider education
- Shared decision-making model
- Follow up to abnormal (positive) FIT

Reducing Structural Barriers

- Mailed FIT
- Transportation
- Open scheduling
- Expanded office hours

Background

Sanford Health serves a large rural community with unique challenges related to accessing colorectal cancer (CRC) screenings. Patients may live 100+ miles away from their locations, making fecal immunochemical test (FIT) drop-off and colonoscopy appointments difficult. Furthermore, Sanford serves those on Native American Reservations where regular access to bathrooms is not guaranteed, so prep for colonoscopy may not be feasible.

Results

As of June 2019, twenty-nine of Sanford Health's primary care clinics were exceeding the 80% CRC screening goal, with a system-wide screening rate of 78%, up 9.4 percentage points from 2015. CRC screening rates decreased in 2020 and 2021 due to challenges with COVID, but Sanford Health remains committed to working toward the 80% goal.

Evidence-based Strategies and Innovations

Sanford Health has implemented several FIT and colonoscopy-focused innovations for increasing rural patients' access to CRC screenings. While using a shared decision-making tool, providers and patients were educated about "the best test is the test that gets completed", focusing on a grant-funded mailed FIT campaign. Patients were empowered to schedule their own colonoscopies and Sanford Health expanded hours and transportation assistance for those who required it. Sanford Health shared the following solutions and lessons learned from their CRC screening interventions:

Provider and Patient Education

The best test is the test that gets completed – focusing on any screening test is better than not screening at all.

Mailed FITs

The health system received a $10K grant from the North Dakota Department of Health Comprehensive Cancer Control Program to implement a pilot project to mail FIT kits to patients in rural and remote areas. The project involved contacting patients to see if they were interested in participating and mailing FIT kits to their homes.

- **Eliminates transportation barriers** by offering patients who live more than 100 miles from the practice the option of having FIT kits mailed to their homes.
- **Use self-addressed stamped envelopes** for FIT returns to minimize inconvenience and cost to patients.
- **Outreach phone calls to existing patients to assess readiness for intervention** – patients were called to see if they were interested in receiving a FIT by mail. Patients were informed that they were overdue for CRC screening, benefits of screening were explained, the test was described, and then they were asked if they'd be interested in receiving a FIT in the mail to complete the test at home and return it to the health center by mail.
- **Mail and track for follow-ups** – If the FIT was not returned within 30 days, the practice phoned the patient with a reminder to return the kit.

Provide Transportation Assistance

For positive or abnormal FIT results requiring follow-up colonoscopy, the health system provides taxi vouchers, as well as occasional overnight lodging assistance to patients who can't get to their follow-up colonoscopy due to transportation barriers.

Saturday Colonoscopy Screening Days

The practice has conducted several Saturday CRC screening day blitzes over the past few years that were both advertised and directly promoted with letter mailings to patients. They have conducted them in March for CRC awareness month and in November and December as well. They found that the November and December timeframe was much more effective, due to insurance coverage and meeting deductibles for the year. These colonoscopy screening events were so successful that they have increased the frequency from one Saturday in March the first year, to now conducting two dates in November and two in December each year.

Use of a Shared Decision-making Communication Tool

The practice uses an internally developed shared decision-making tool to start the conversation between the staff and the patient about the three CRC screening test options they offer (FIT, mt-sDNA and colonoscopy). Patients are offered a one-page, pocket-card handout that describes available screening options. The shared decision-making tool is also available for patients to download from the patient portal.

Enable Patients to Schedule Their Own Colonoscopy via the Patient Portal

The patient portal automatically displays an alert when patients are of age and overdue based on their screening schedule. Since the practice is part of an integrated health system, the patient can schedule their colonoscopy directly from the patient portal which is then triaged by an RN in the scheduling department. Patients are either scheduled for a procedure based on past history without having to get an order from their primary care physician or are scheduled for a gastroenterology consult. Staff encourage the use of the patient portal at every visit or have them sign up if they're not already connected.

Tool Shared

Homegrown shared decision-making tool – **Appendix CS08-1**.

Interviewee

Stacey Will, MSB, BSN, RN
Quality Improvement Advisor
Sanford Health

CASE STUDY SPOTLIGHT

Tiburcio Vasquez Health Center

Type
Federally Qualified Health Center

Location
Alameda County, CA

EHR
OCHIN-Epic

27,492
patients

- 92.0% of patients at or below 200% Federal Poverty Guideline
- 60.8% of patients are best served in a language other than English
- 28.0% of patients are uninsured

4
locations

Union City | Hayward | San Leandro | Fremont

Patient Strategies

- Patient reminder or recall/in reach
- Patient education
- Navigator/Community Health Worker

Clinician/Staff Strategies

- Provider reminder or recall
- Care team/team-based approach

Reducing Structural Barriers

- Open scheduling
- Expanded office hours

Background

Tiburcio Vasquez Health Center (TVHC) placed a focus on increasing colorectal cancer (CRC) screening rates after identifying that in 2016 the health center's CRC screening rate was below the national average for Federally Qualified Health Centers (FQHCs).

Results

Between 2017 and 2019, the practice increased CRC screening rates from 33% to 40%.

Evidence-based Strategies and Innovations

TVHC used multiple strategies to increase their CRC screening rates, including reducing structural barriers by offering expanded office hours and mailed fecal immunochemical tests (FITs). All staff in the participating clinics were engaged in the CRC screening efforts and educated about the importance and handling of FITs. Patient education and reminders were also essential to success, as well as designating a Medical Assistant (MA) to assist in the process. TVHC shared the following solutions and lessons learned from their CRC screening interventions:

Mailed FITs

- The practice has a dedicated MA who spends four hours per week on mailed FIT processes.
- TVHC adapted successes from different practices, such as putting labels on kits to remind the patient to add the date the sample was completed. The MA also sends reminders to patients to keep the kit in the bathroom for easier access.

The Health Center Sought Ways to "Normalize Poop" with Staff

- TVHC allowed open dialogue with non-clinical staff to discuss concerns and provided education to them on the importance of accepting FIT kits.
- The front office staff were the ones receiving the FIT kits and had to get used to it. The message shared with them was, "This is something that can save someone's life". Providers and MAs normalized the process of FIT collection in their practice by creating a supportive and open environment.

Patient Education and Communication

After-visit summaries provided to patients who take home a FIT include an illustrated, wordless instruction sheet developed by the Kaiser Permanente Center for Health Research. The practice then follows up with patients by text message. This is available in **Appendix CS09-4**.

Birthday Card Reminder Campaign

- TVHC implemented a birthday reminder campaign for existing patients who have both a birthday and an upcoming appointment. They mail FIT kits to these patients and give them a choice to either return their completed kit by mail or bring it with them when they come in for their visit.
  - The key to success with this campaign is that patients are already making an investment in their health. Patients that received these reminders had been in for an appointment within the last 18 months and had an upcoming appointment in six weeks.
  - Patients who had not been in for a recent visit or did not have an upcoming appointment were much less likely to return a completed FIT.
- An alert is placed in the chart and during the reminder call for the visit. The MA encourages the patient to bring in the test or return it via mail.

Addressing Structural Barriers

- In addition to offering same-day and urgent appointments, the practice also provides after-hours appointments, some Saturday appointments, a mobile van, and outdoor wellness clinics where patients can obtain FITs. They also implemented a "poop on-demand" option, which offers patients the opportunity to provide a stool sample for testing while in the office.
- One of the structural barriers the practice encountered was that patients didn't want to walk upstairs to the lab to drop off their completed FIT kits. Additionally, both the lab and post office would frequently reject mailed FIT kits from patients. To address this issue:
  - The health center worked with the lab supervisor to agree on a process where the patient returns the kit to the clinic's front desk staff, who then hand-deliver the specimens to the lab.
  - Part of normalizing the FIT kits with front office staff included providing them with gloves and having them agree to deliver the kits daily to the lab (sometimes several times a day). This not only assisted patients who were unable or unwilling to climb stairs, it also eliminated the barrier of both the lab and the post office rejecting mailed kits.

Tools Shared

- Photo of FIT colon reminder – the graphic is stuck to all the computers in the adult medicine clinic as a reminder to check CRC screening status – **Appendix CS09-1**.
- Flyer promoting colorectal cancer screening to African American patients – **Appendix CS09-2**.
- Mailed FIT workflow (used by MAs until centralized care coordination staff are available), when order is sent it goes to a centralized work queue for mailing – **Appendix CS09-3**.
- Wordless FIT instructions for patients – the health center uses the Kaiser Permanente Center for Health Research wordless FIT instructions – **Appendix CS09-4**.

Interviewees

Blair Brown, MD
Senior Director, Population Health and Quality Improvement
Tiburcio Vasquez Health Center

Jessica Jamison, MPH
Former Director, Patient and Community Engagement
Tiburcio Vasquez Health Center

CASE STUDY SPOTLIGHT

Zufall Health Community Health Centers

ZUFALL HEALTH COMMUNITY HEALTH CENTERS

Type
Federally Qualified Health Center

Location
Dover, NJ

EHR
eClinicalWorks

41,497
patients

- 87.9% of patients at or below 200% Federal Poverty Guideline
- 66.4% of patients are best served in a language other than English
- 51.6% of patients are uninsured

Patient Strategies

- Patient reminder or recall/in reach
- Patient education
- Reducing client out-of-pocket costs
- Navigator/Community Health Worker
- Automated campaigns
- Patient incentives

Clinician/Staff Strategies

- Provider reminder or recall
- Provider education
- HIT interventions dashboard
- Standing orders
- Follow up to abnormal (positive) FIT

Background

In 2015, Zufall Health Community Health Centers' (Zufall Health's) colorectal cancer (CRC) screening UDS rate was 50%. Zufall Health prioritized CRC screening after engaging with the Screen NJ Initiative and identifying a burden on individual providers managing the entire CRC screening process on their own.

Results

By employing CRC screening navigators as additional support for providers, completing follow-up colonoscopies, and provider feedback/assessments, the health center increased its UDS CRC screening rate to 65% in 2019.

Evidence-based Strategies and Innovations

Zufall Health used multiple strategies to improve its CRC screening rates and processes. The health center credits employing six CRC screening navigators who dedicated r time to providing support to the practice in conducting outreach, education, and follow-up of patients due for CRC screening as essential to their success. Additional patient-focused strategies include patient education, reminders, reducing out-of-pocket costs, and patient incentives. Clinician and staff-focused strategies include educating staff and providers and using dashboards to track progress. The health center shared the following summary of solutions and lessons learned while improving CRC screening in their practices:

CRC Screening Navigation

Over the last several years, Zufall Health has been funded to provide CRC screening and navigation at seven of their locations by **Screen NJ**, an initiative between Rutgers Cancer Institute of New Jersey and the New Jersey Department of Health to increase CRC screening rates. Zufall Health's six CRC screening navigators are medical assistants (MAs) who receive special training to conduct outreach, communicate with, and follow up with patients throughout all steps of the CRC screening process. The CRC screening navigators also work very closely with and provide additional support to the primary care providers. Navigators receive specialized training on the importance of CRC screening, current practice guidelines, health center screening rates, and practice workflow for ordering tests, communicating with patients and providers, and following up with patients with their test results.

Reducing Patient Out-of-pocket Costs

The Screen NJ Initiative also helps subsidize the cost of FITs and colonoscopies so that the cost is not a burden to the patient.

FIT Champions

The CRC screening navigators are empowered to remind providers about patients who are due for CRC screening. They reinforce the Clinical Decision Support System (CDSS) alerts in the EHR, which identify patients due for screening. They also remind providers to order the FIT or colonoscopy by entering the standing orders for the providers when rooming the patient.

The CRC screening navigators receive specialized training that enables them to speak with patients about the importance of CRC screening. When the provider meets with the patient, the educational message is reinforced, and that helps patients to better understand why they should complete the screening test.

Peer Learning and Mentoring

The CRC screening navigators meet at least quarterly to discuss how best to encourage patients to return their FITs and follow through with colonoscopy if needed. The more experienced CRC screening navigators facilitate the discussions and are also champions within the practice to ensure that providers and front desk staff are aware of workflows for distributing and receiving FIT kits. The quality improvement process of using Plan-Do-Study-Act (PDSA) cycles of change for implementing evidence-based interventions is discussed. For example, screening navigators might volunteer to test the process of mailing FIT to patients that are due or overdue for screening. During these meetings, the team shares successes and ideas that have worked at their site for implementation at other sites.

Dashboards

Quarterly reviews of the health center's CRC screening dashboards and providing shout-out "gold stars" to teams with the highest results helps to motivate providers and teams to outperform each other and continuously improve their outreach and follow up with patients to complete their screenings.

Text and Voicemail Messaging Campaigns

Zufall Health uses the Luma Health text and voicemail messaging platform, coupled with an EHR-based patient registry, as an initial reminder to encourage patients to schedule their appointments for CRC screening. The messages lead with, "Our records show it is time for your colorectal cancer screening." By using an automated messaging campaign first, it helps reduce the number of calls that the CRC screening navigators need to make to follow up with patients who are due for screening but haven't yet scheduled their appointments.

Front Desk Staff Training

The practice trains the front desk staff on how to greet and assist patients who bring completed kits back to the office and where to drop them off when returning them.

Contactless FIT Drop-off Boxes

During the COVID-19 pandemic, Zufall Health set up several contactless drop-off boxes where patients can return their completed FIT without entering the building.

Patient Incentives

The practice provides $10 gift cards to all patients who return their completed FITs to the practice. The CRC screening navigators promote incentives to patients when providing them with instructions about how to do the test.

Positive FIT Dashboard

The focus of the Positive FIT dashboard is to enable follow-up with patients who have positive (or abnormal) FIT results. Within one week of receiving positive or abnormal FIT results, CRC screening navigators call patients and assist them in scheduling their follow-up colonoscopy.

Tools Shared

- Contactless FIT drop-off box (photograph provided) – **Appendix CS10-1**.
- Sample positive FIT dashboard used for quality improvement – **Appendix CS10-2**.
- Standing order policy for MAs – **Appendix CS10-3**.
- PowerPoint for MA training – **Appendix CS10-4**.
- Sample patient text and voicemail reminders – **Appendix CS10-5**.
- Sample quarterly patient newsletter with an article about FIT incentive – **Appendix CS10-6**.

Interviewees

Rina Ramirez, MD
Chief Medical Officer
Zufall Health Community Health Centers

Kathleen Felezzola, RN
Director of Nursing
Zufall Health Community Health Centers

Kathy Orchen, PA, MPH, MS
Quality Assurance Program Manager
Zufall Health Community Health Centers

CASE STUDY APPENDICES

CS01-1

Script for providers:

I will agree to allow you to be screened with a FIT (or FIT-DNA) if you promise me that you will do a colonoscopy if the result is positive.

Script for MA/RN contacting the patient with positive FIT result who is reluctant to proceed with diagnostic colonoscopy:

- Dr. _____ will be very concerned that you do not want to have the colonoscopy done. He/She thinks it is very important to do that.
- The colonoscopy is needed because a positive result on a FIT test can be the first warning sign that there is a polyp or colorectal cancer.
- Yes your hemorrhoids may have been bleeding, but you could also have a polyp or cancer. The only way to make sure you are OK is to have the colonoscopy done.
- No. We never order second FIT tests to make see if the bleeding has gone away. Every positive FIT needs a colonoscopy to rule out more serious causes of bleeding.
- I am going to let Dr. _____ know today that you do not want to do the test. He/She may reach out to you letting you know how important it is to get this done.

Mailed letter for monthly positive FIT/colonoscopy procrastinators:

Dear _____

As your Primary Care Physician at Premier Medical Associates, I am writing to ask you to schedule a very important test.

Our records show that within the past month, you completed an at-home stool test for colorectal cancer screening which showed a positive result. As a result, I recommended that you have a colonoscopy. To date, our records show that you have not completed your colonoscopy, and as your doctor, I am very concerned.

A positive test result is sometimes a warning sign that a person has pre-cancerous colon polyps (growths) that need to be removed to prevent them from turning into colorectal cancer. Rarely, a positive test is a warning sign of early-stage colorectal cancer that needs to be taken care of promptly.

If our records are inaccurate and you have had a colonoscopy done, please contact your GI doctor and have them forward your results to our office. If you have not had a colonoscopy done, it is critical that you do so and I ask that you contact our office in the next 10 days, or as soon as possible, to schedule this test.

Let's face it, few people consider themselves at risk for cancer and these screenings are very easy to put off. For some reason, the idea of a colonoscopy itself is daunting. However, the reality is that colorectal cancer is the second leading cause of cancer-related deaths in Pennsylvania and the United States.

Most colorectal cancer-related deaths can be prevented. If detected early, this cancer has a 90% survival rate. Early detection can mean the difference between life and death. Our team at Premier Medical Associates stands by to assist you any way we can.

If you have questions about how this test is done, how it will be paid for, or any other concerns we can address or you or a member of your family as you follow through on this important test, please contact our GI nurse at 412-457-0427.

Sincerely, Dr. _____

Robocall/text (sent 1 month before 50th birthday if a patient has never been screened before)

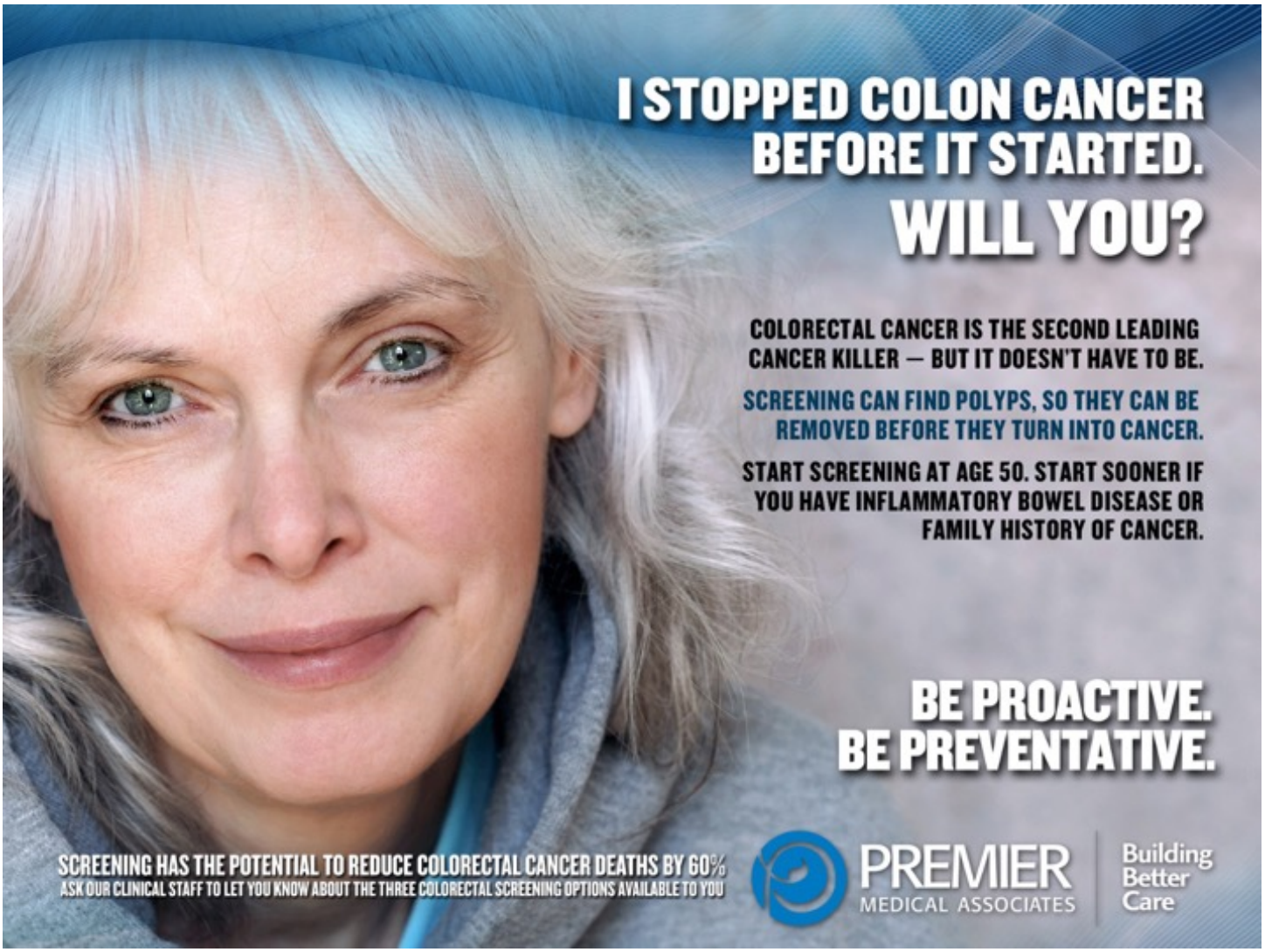
Happy 50th Birthday!

Colorectal cancer rates are increasing for the 50-54 year age group.

A colonoscopy isn't the only option for colorectal cancer screening. There are simple, affordable options, including tests that can be done at home. Talk to your doctor about which option is right for you. Ask which tests are covered by your health insurance.

CS01-2

Exam Room Poster – Allegheny Health Network / Premier Medical Associates



CS01-3

Examples of CRC Screening Dashboard Displays

CRC Screening Rates by Office – Year ending 6/30/2020

Site of Care	Patient Count	Prior Report Screening Rate	Current Screening Rate	Trend
IM OMC	2,607	86.5%	86.1%	↓
FP Mon	2,156	84.3%	84.8%	↑
FP Irwin	2,372	82.5%	81.0%	↓
FP FH	1,398	80.5%	81.0%	↑
FP GM	3,430	81.9%	80.8%	↓
IM NV	2,007	79.5%	80.6%	↑
FP PH	3,818	77.6%	77.8%	↑

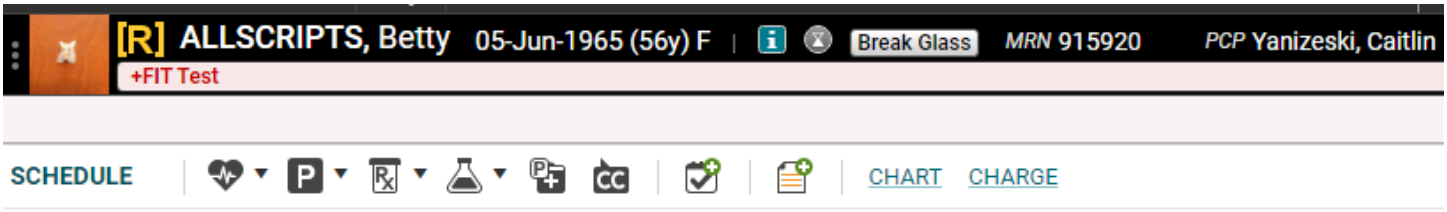
Provider-by-provider CRC Screening Rates (original dashboard)

	1/1/16	10/1/15	7/1/15	4/1/15	1/1/15	10/1/14	7/1/14	4/1/14	target
Dr. Brown	91.8	90.7	89.4	88.9	86.4	88	88.1	88.5	80
Dr. White	90.3	89	89.5	89.3	88.5	87.5	88.1	86.7	80
Dr. Black	89.9	88.7	87.3	84.8	86.2	83.1	83.6	80.1	80
Dr. Blue	88.8	86.8	84.2	80.9	79.4	75.2	73.2	71	80
Dr. Green	85.8	84.7	84.9	83.7	86	84.1	82	79	80
Dr. Gold	85.6	86.1	85.8	85.3	84.1	83.7	83.1	82.7	80
Dr. Scarlett	85.4	85.3	85.2	85.2	83.9	82.6	82.2	82.1	80
Dr. Goldenrod	84.6	86	83.5	81.2	80.7	77.8	78.9	78.2	80
Dr. Olive	83.9	82.5	83.7	82.7	82.7	82.5	83.1	82.4	80
Dr. Forest	83.3	82	82	80.1	80.1	79.2	80.2	78.6	80
Dr. Cerulean	83.1	83.5	82.9	82.6	83.8	82.2	81.1	79.9	80
Dr. Periwinkle	82.4	82.4	82.9	81.1	81.1	81.6	80	79.6	80
Dr. Fushia	82.3	79.5	76.3	73.2	75.8	74.7	75.3	72.9	80
Dr. Mulberry	80.8	79.4	79.1	80.3	76.5	71.3	66.3	61.8	80
Dr. Sienna	80	80	80.2	80.7	79.5	80.5	81.1	80.9	80
Dr. Van Dyke	76.6	77.1	75.7	73.2	73.2	74.7	74.5	74.8	80
Dr. Umber	76	75.2	75	77	77.1	77.7	76.5	76.9	80
Dr. Gray	75	72.9	73.9	72	70.5	69.5	68.6	68	80
Dr. Maroon	74.7	73.1	73	72.8	72.3	72.1	71.6	68.9	80
Dr. Maize	72.7	72.5	72.1	70.7	70.8	72.5	74.1	73.6	80
Dr. Robin	71.6	70.8	69.3	68	70.9	72.5	74	72	80
Dr. Wisteria	68.1	67.8	67.6	66.7	63.9	61	59.2	55.7	80
Dr. Jazzberry	65.8	63.5	61.3	60.1	59.2	59.4	59	58.8	80
Dr. Cerise	65.2	64.8	64.4	65.5	66	64.3	67.3	68.7	80

CS01-4

Positive FIT Alert in EHR and Positive FIT Registry Screenshots

Positive FIT Alert in EHR (shown on Test Patient, Betty)



Positive FIT Registry

This report is sent out weekly to providers for their patients who had a positive FIT Test

Patient name	DOB	MRUN	Date of + FIT	Home office	Provider	Action taken	Patient mailing address

CS03-1

Patient pictorial instruction sheet

Instructions have been modified by EBNHC. Courtesy of Kaiser Permanente Center for Health Research.

QR codes to access the patient videos on YouTube

QR Code

- ✓ Video English and Spanish
- ✓ Posted on YouTube
- ✓ QR code activated
- ✓ Language Specific QR code "activated" 6/1/2021 AVS
- ✓ Viewed (as of 6/3/21):
  - English = 275 views
  - Spanish = 150 views

ENGLISH

SCAN ME

https://www.youtube.com/watch?v=jXLIvgWNW1A

SPANISH

SCAN ME

https://www.youtube.com/watch?v=4PMxLj8Jwv4

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CS03-2

Incentive flyer

CS03-3

Listing of fields used from EHR to report on inadequate/incomplete tests

Selected Columns	Width
MRN (EPT) [367]	1440
Patient DOB [54500]	1440
First Name [2208]	2160
Last Name [2209]	2160
Phone Number (EPT) [2245]	1800
Patient Preferred Language [1132]	1440
Patient Gender Identity [1938]	1440
Patient Address [15197]	2880
PCP [54502]	1440
PCP Department [4044]	2160
ORDERING PROVIDER [1150]	3000
Ordering Provider ID [42189]	1080
Ordering Provider NPI [84609]	2000
Order Date [1052]	1080
Order Patient DAT [34903]	0
Order Patient Internal ID [34904]	0
Age of Order [20195]	1440
Lab Order Status [51220]	1440
Order Status [51223]	1900
Comment Resuts [100811]	1440
Comment with cancellation [100810]	0
Order Patient Name and MRN [84521]	0
Order ID [52000]	0
ORDERS NEEDING COSIGN [20113]	2880
Cosigner User ID [4483]	2700

CS03-4

Screenshots of Provider Alert in Epic Storyboard and sample one-click order for FIT kits

Colorectal Cancer Screening

Measure Description:

Measure Description: Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer (in 2019).

Numerator: Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria:

- Fecal occult blood test (FOBT) during the measurement period.
- Fecal immunochemical test (FIT)-deoxyribonucleic acid (DNA) during the measurement period or the 2 years prior to the measurement period.
- Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period.
- Computerized tomography (CT) colonography during the measurement period or the 4 years prior to the measurement period.
- Colonoscopy during the measurement period or the 9 years prior to the measurement period.

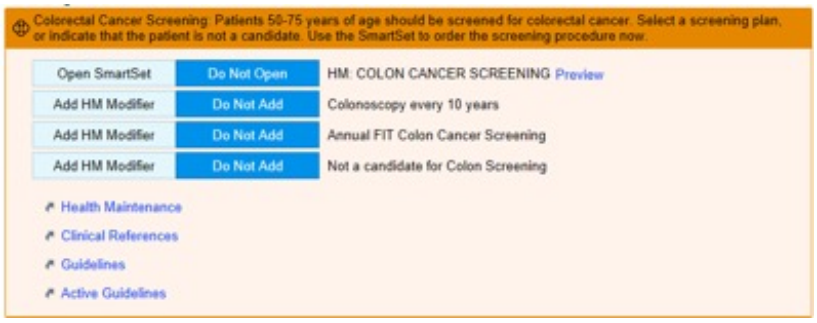
Denominator: Patients 50 through 75 years of age with a medical visit during the measurement period.

Exclusions/Exceptions:

- Numerator: Not applicable
- Denominator:
  - Patients with a diagnosis of colorectal cancer or a history of total colectomy.
  - Patients who were in hospice care during the measurement period.

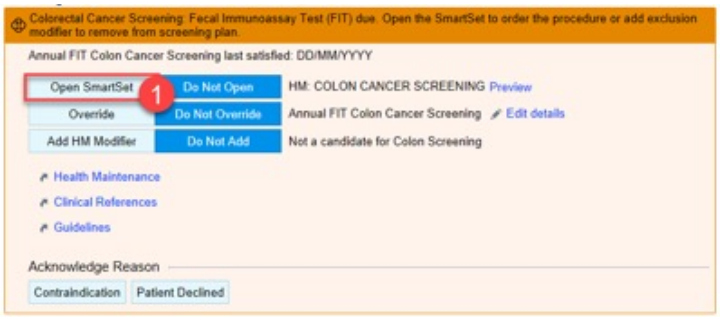
Workflow:

When the patient turns 50 years of age the provider is prompted to select a Colorectal Cancer (CRC) Screening plan. Patients who are low risk: no family history of colorectal cancer, no prior history of colon polyps, and do NOT have a history of hemorrhoids and/or rectal bleeding are suitable for yearly FIT screening.

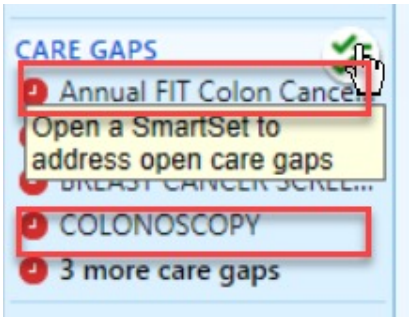


When the patient is due for Colorectal Cancer Screen:

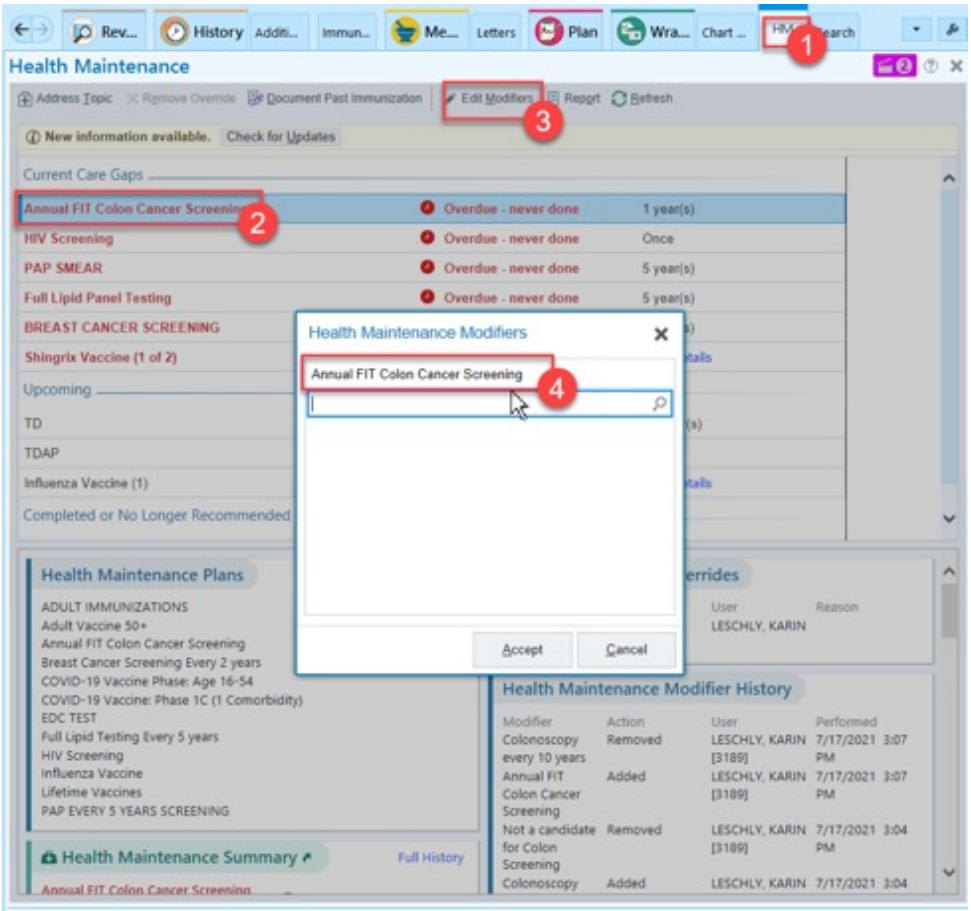
MAs: Order the FIT by opening the SmartSet on the Fecal Immunoassay Test (FIT) Best Practice Alert.



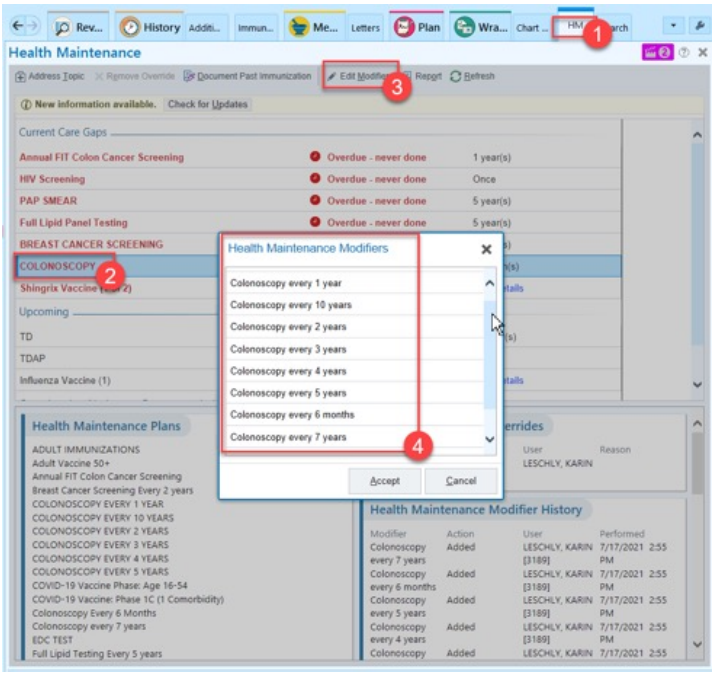
Providers: Order the FIT or Colonoscopy through the Care Gap SmartSet on StoryBoard.



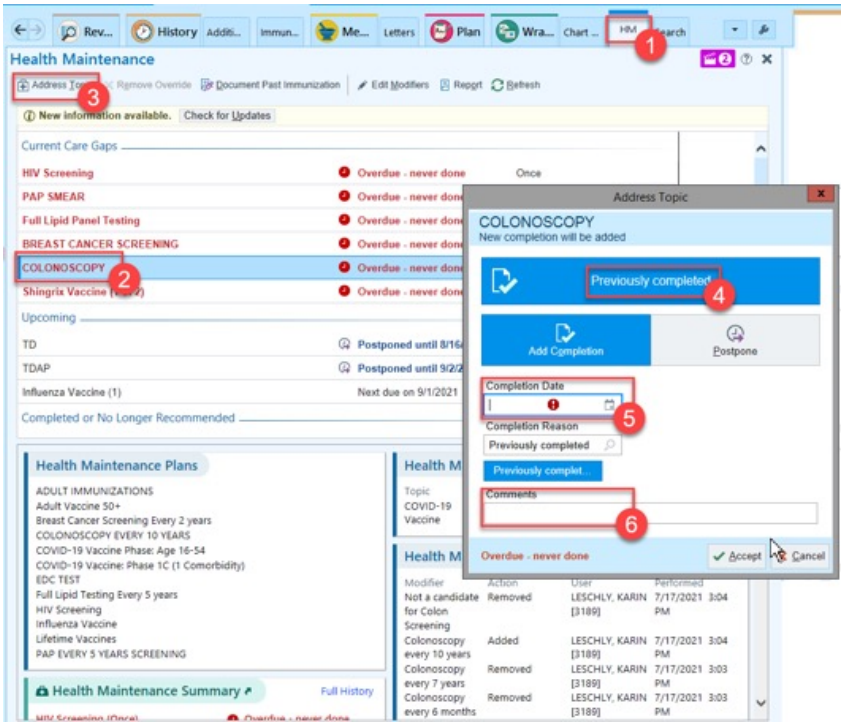
If the patient needs to be taken off the FIT Health Maintenance Topic, **Modify** the Annual FIT Colon Cancer Screen by removing it.



If the patient needs a colonoscopy at an interval other than 10 years **Modify** the Colonoscopy Health Maintenance Alert by selecting the appropriate Health Maintenance Modifier.

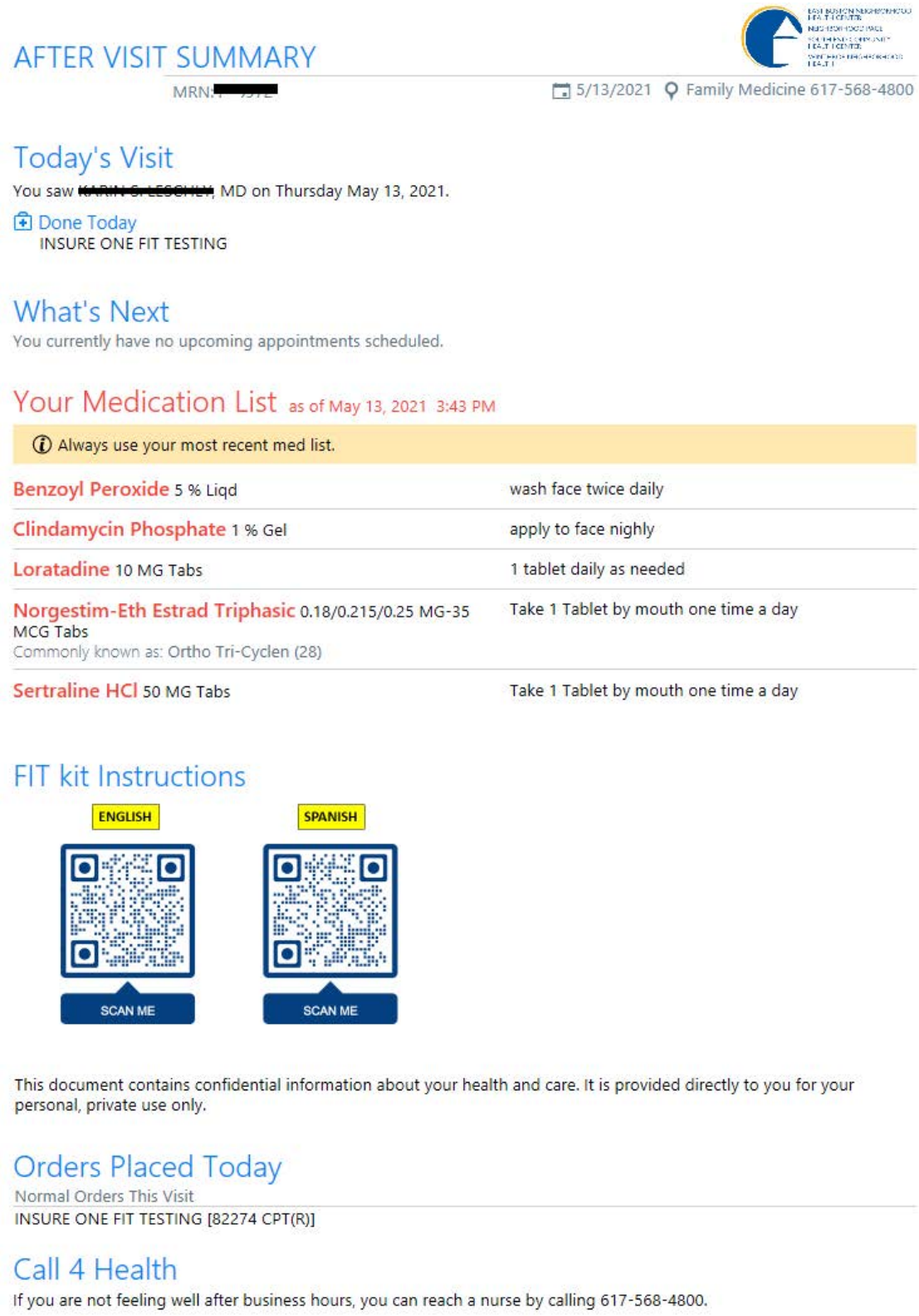


If the patient has had completed their Colonoscopy at an outside organization **Address** the Colonoscopy Health Maintenance Topic by entering the completion date. CareEverywhere FIT results are mapped.



CS03-5

Screenshot of after-visit summary from a test patient portal account that includes patient instructions for FITs



AFTER VISIT SUMMARY

MRN: [redacted]

5/13/2021 Family Medicine 617-568-4800

Today's Visit

You saw [redacted] MD on Thursday May 13, 2021.

Done Today
INSURE ONE FIT TESTING

What's Next

You currently have no upcoming appointments scheduled.

Your Medication List as of May 13, 2021 3:43 PM

Always use your most recent med list.

Benzoyl Peroxide 5 % Liqd	wash face twice daily
Clindamycin Phosphate 1 % Gel	apply to face nighly
Loratadine 10 MG Tabs	1 tablet daily as needed
Norgestim-Eth Estrad Triphasic 0.18/0.215/0.25 MG-35 MCG Tabs Commonly known as: Ortho Tri-Cyclen (28)	Take 1 Tablet by mouth one time a day
Sertraline HCl 50 MG Tabs	Take 1 Tablet by mouth one time a day

FIT kit Instructions

ENGLISH SCAN ME

SPANISH SCAN ME

This document contains confidential information about your health and care. It is provided directly to you for your personal, private use only.

Orders Placed Today

Normal Orders This Visit

INSURE ONE FIT TESTING [82274 CPT(R)]

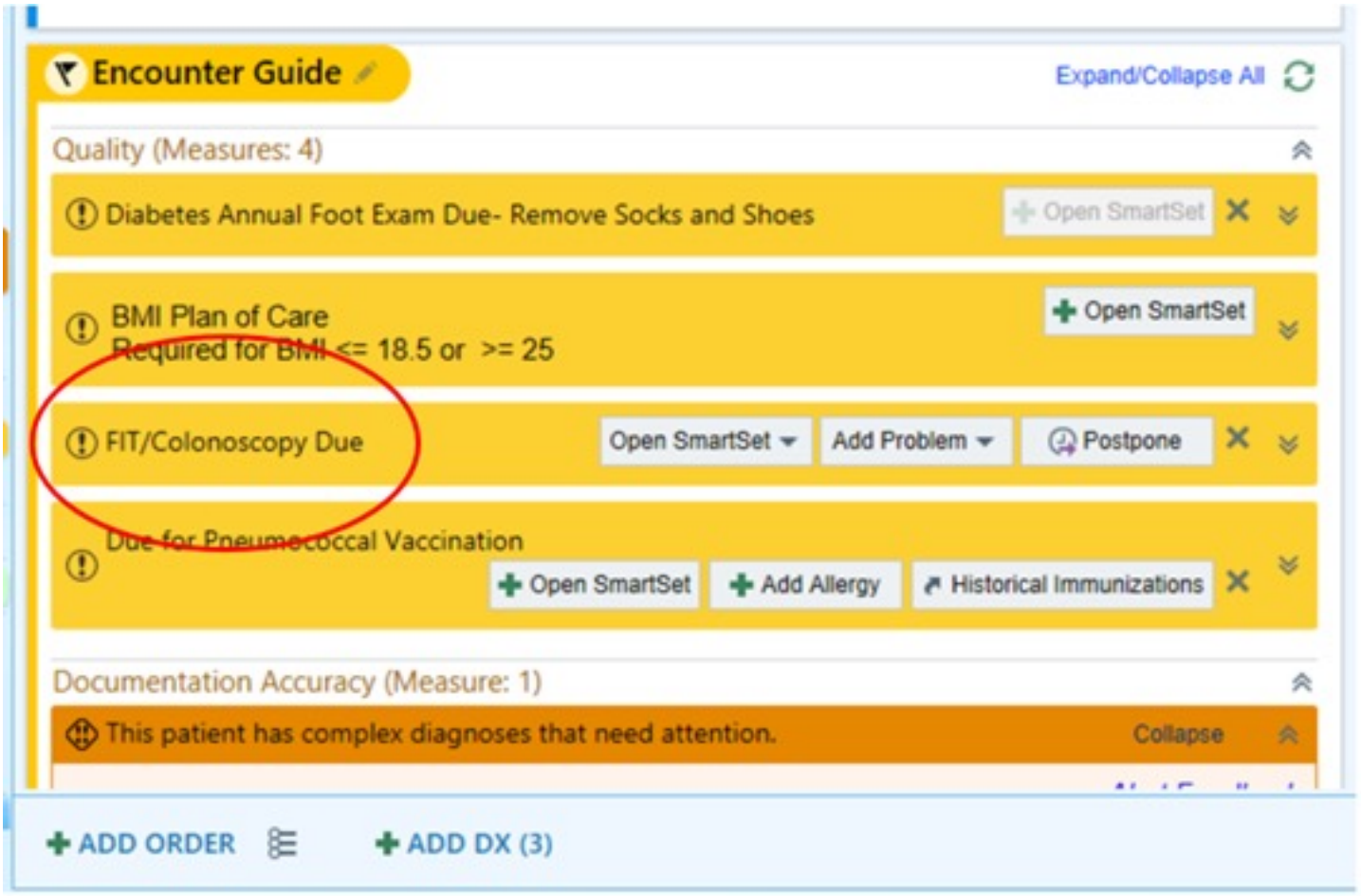
Call 4 Health

If you are not feeling well after business hours, you can reach a nurse by calling 617-568-4800.

CS05-1

Encounter Guide Screenshot from Epic

Point of Care Prompt Example used by Mercy Health System to alert provider that patient is due for Colonoscopy



CS05-2

Normal FIT Patient Result Letter Template

[Date]

[First Name] [Last Name]

[Address]

[City,] [State] [ZIP]

Dear [First Name],

You recently completed a Fecal Immunochemical Test (FIT) to check for colorectal cancer. The results of your FIT test were **normal**, meaning there was no blood found in your stool at the time of the test.

Next Steps

Regular screenings can help protect you from colorectal cancer. The U.S. Preventative Services Task Force recommends screenings at ages 50 to 75. A screening colonoscopy for adults of average risk can be done every 10 years. Alternatively, a FIT test can be done yearly.

If you have a Mercy primary care provider, a copy of these results has been shared with them. *If you do not have a primary care provider, we can help you locate a Mercy physician. Visit Mercy.net to find a doctor.*

Catch it Early

Remember, although colorectal cancer can be deadly, it can be cured if caught early. Screening is key to early detection and prevention of cancer. To learn more about colorectal cancer screening tests, go to insert URL.

Congratulations on taking an important step in protecting your health!

Sincerely,

Your Mercy Care Team

Abnormal FIT Patient Follow-up Letter Template

[Date]

[First Name] [Last Name]

[Address]

[City,] [State] [ZIP]

Dear [First Name],

You recently completed a Fecal Immunochemical Test (FIT) to check for colorectal cancer. The results of your test were abnormal, showing blood in your stool.

An abnormal result does not necessarily mean that you have colorectal cancer, but it does mean that additional testing is needed. Your doctor may recommend that you follow up with a colonoscopy to find the source of your bleeding and to determine if a polyp or cancer is present.

Next Steps

Schedule an appointment with your primary care provider and let them know that you tested positive for blood in your stool (FIT Test). If you have a Mercy primary care provider, a copy of these results has been shared with them. *If you do not have a primary care provider, we can help you locate a Mercy physician. Visit Mercy.net to find a doctor.*

Learn More

Remember, although colorectal cancer can be deadly, it can be cured if caught early. Screening is key to early detection and prevention of cancer.

A colonoscopy can protect your health. If colorectal cancer is caught early with a colonoscopy, 9 out of every 10 people with the disease can be cured. If you have colorectal cancer and do not get tested, you may miss out on the chance for early and more effective treatment.

To learn more about colonoscopy go to insert URL

Sincerely,

Your Mercy Care Team

Script for Abnormal FIT Result

Hi [Patient Name],

This is [Caller's First Name]. I work with Dr. [PCP] at Mercy. You recently completed a Fecal Immunochemical Test (FIT) to check for colorectal cancer. The results of your test were abnormal, showing blood in your stool. Dr. [PCP] would like for you to schedule an appointment to discuss the next steps.

IS NOW A GOOD TIME TO SCHEDULE AN APPOINTMENT?

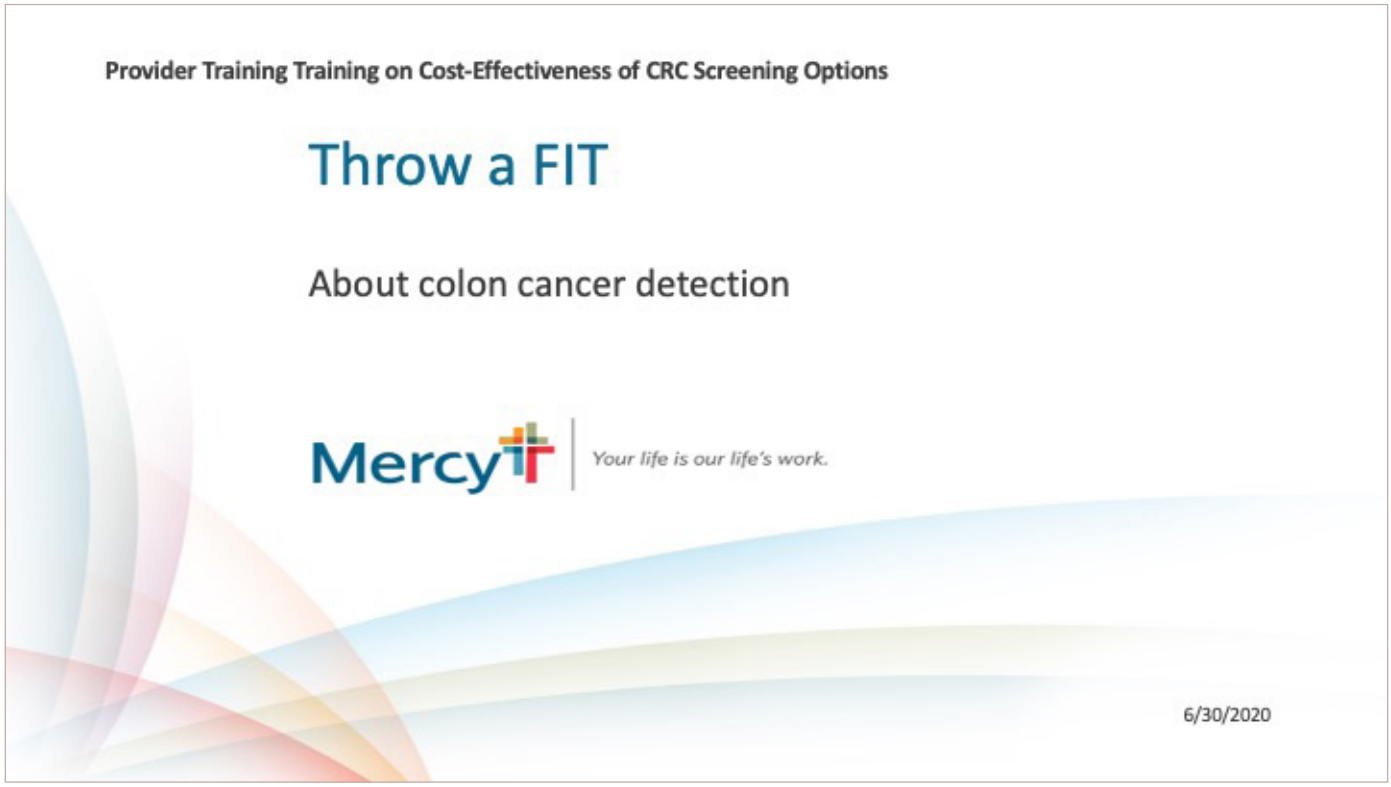
- **"Yes"** → (Book the appointment and confirm.) You are scheduled for _____ day and time with (doctor or APP name). He/she will have a copy of your results and a copy will also be mailed to you.
- **"No"** → I recommend that you call and schedule an appointment with Dr. (Mercy PCP's) office within the next two weeks. He/she will have a copy of your results and a copy will also be mailed to you.
- **"I'm no longer seeing Dr. [Mercy PCP]."** → Do you have a primary care provider?
  - **"Yes"** → Please share a copy of your results with your provider. A copy of your results will also be mailed to you. Call their office to schedule an appointment and to talk about your abnormal results and next steps.
  - **"No"** → Do you need help finding a Mercy primary care provider?
    - **"Yes"** → (Can look up providers with new patient appointments available. Book the appointment and confirm.) You are scheduled for _____ day and time with (doctor or APP name and address). He/she will have a copy of your results and a copy will also be mailed to you.
    - **"No"** → I recommend that you call and schedule an appointment with a primary care provider within the next two weeks. A copy of your results will also be mailed to you. Schedule an appointment to talk about your abnormal results and next steps.

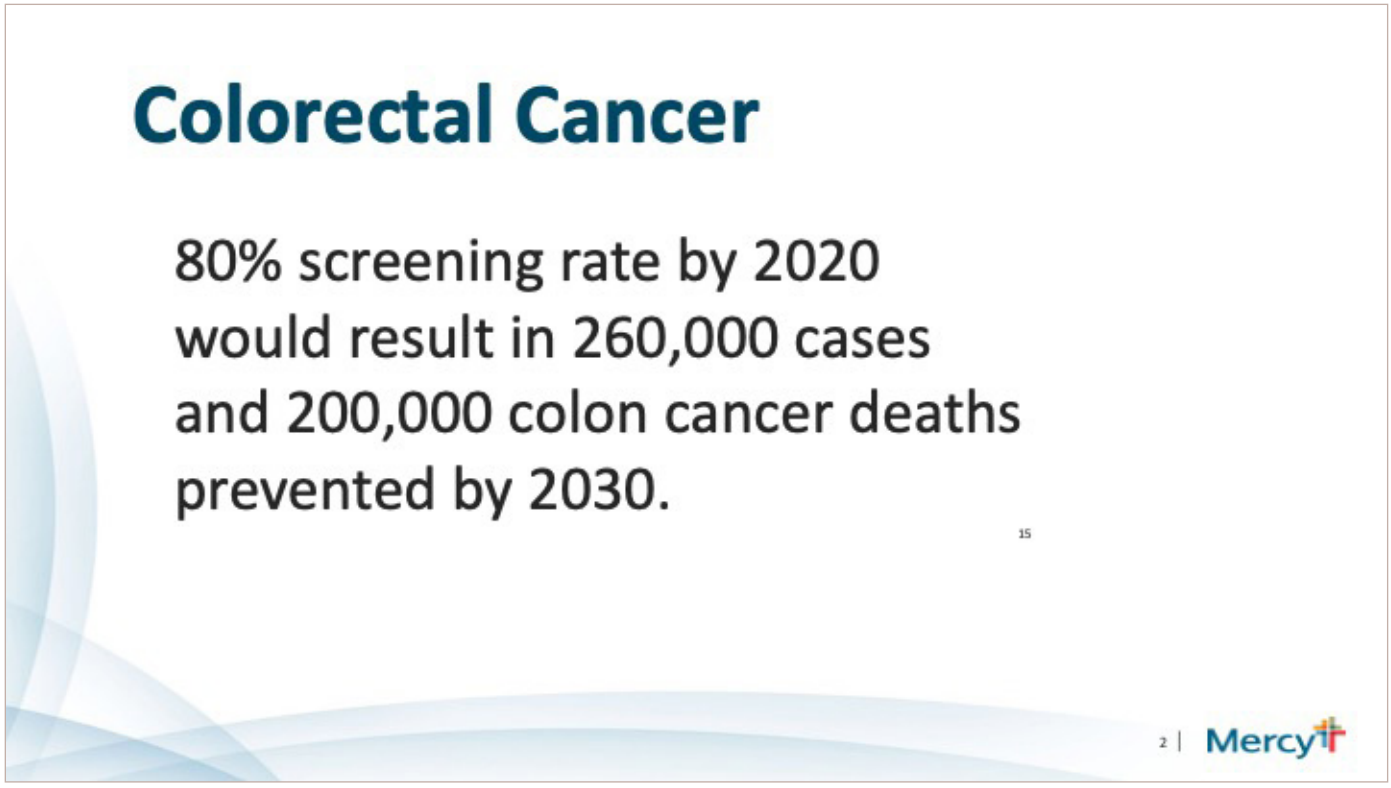
Question and Answer

- **"Why do I need to do this?"** OR **"Does this mean I have cancer?"** An abnormal result does not necessarily mean that you have colorectal cancer, but it does mean that additional testing is needed. Your doctor may recommend that you follow up with a colonoscopy to find the source of your bleeding, and to determine if a polyp or cancer is present. A colonoscopy can protect your health. If colorectal cancer is caught early with a colonoscopy, 9 out of every 10 people with the disease can be cured. If you have colorectal cancer and do not get tested, you may miss out on the chance for early and more effective treatment.
- **"Where can I learn more about a colonoscopy?"** To learn more about colonoscopy go to insert URL

CS05-3

Information on how to provide patient-centered, cost-effective CRC options to patients in making the decisions ("Throw a FIT" provider training slides).





Procedure "costs"

Test	Prof MCR FEE	Prof Fee sch	Total Fee MCR/Fee
Colonoscopy 10 yrs	$308.63*	$1109*	38.86/110.90*
Flex Sig 5 yrs	$158.57*	$324*	31.74/64.80*
CT colonography 5 yrs	$117.75*	$462*	23.55/92.40*
DNA stool 3 yrs	$508.87	$1098	169.62/366
FIT 1 yr	$18.05	$66	18.05/66
FOBT 1 yr	$15.92	$66	15.92/66

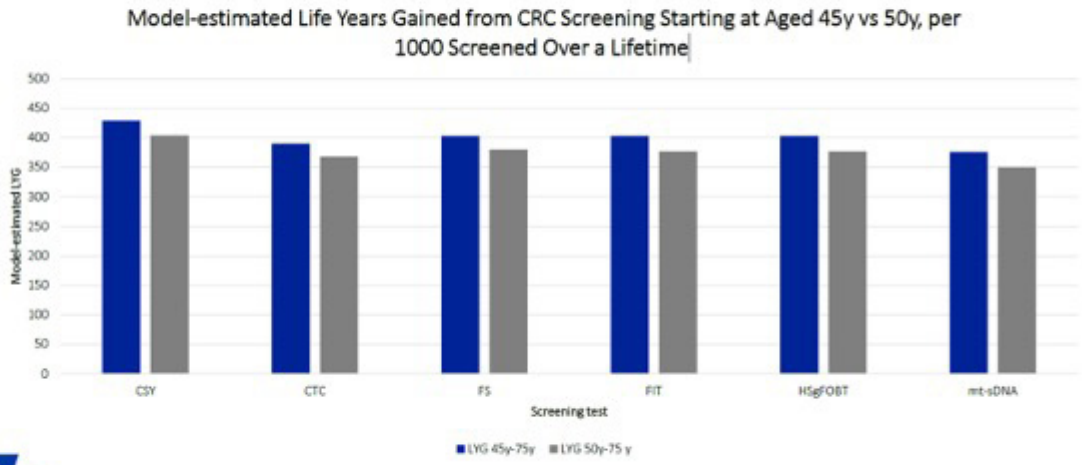
* Does not include facility fees

The American Cancer Society Guidelines

- Any of the recommended screening options can be used.
  - 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

CSY – Colonoscopy
CTC – CT colonography
FS – Flexible Sig
FIT – fecal immunochemical
HSgFOBT – Guiacs
Mts-DNA - Cologuard



@RichWender

Source: Wolf AMD, Fontham ETH, Church TR, et al. Colorectal cancer screening for average-risk adults: 2018 guideline update from the American Cancer Society. CA Cancer J Clin. 2018; 68: 000-000

5 | Mercy

Result of delays

Incidence rates are going up among patients 50 to 54.
Only 51% of patients 50 to 54 are up-to-date with screening.

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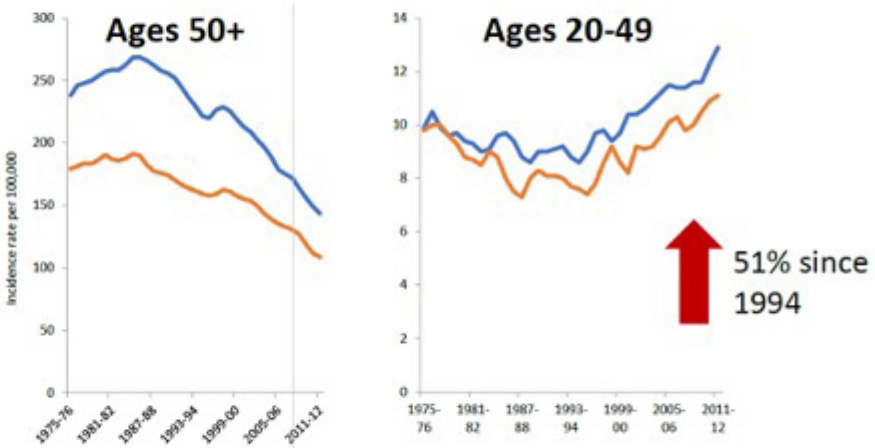
Recent Developments in Colorectal Cancer Burden

Rising colorectal cancer incidence among people under age 50.[1]



@RichWender

1. Siegel et al. Colorectal Cancer Incidence Patterns in the United States, 1974-2013. J Natl Cancer Inst 2017;109.
SEER 9 delay-adjusted rates, 1975-2012; 2-year moving average.

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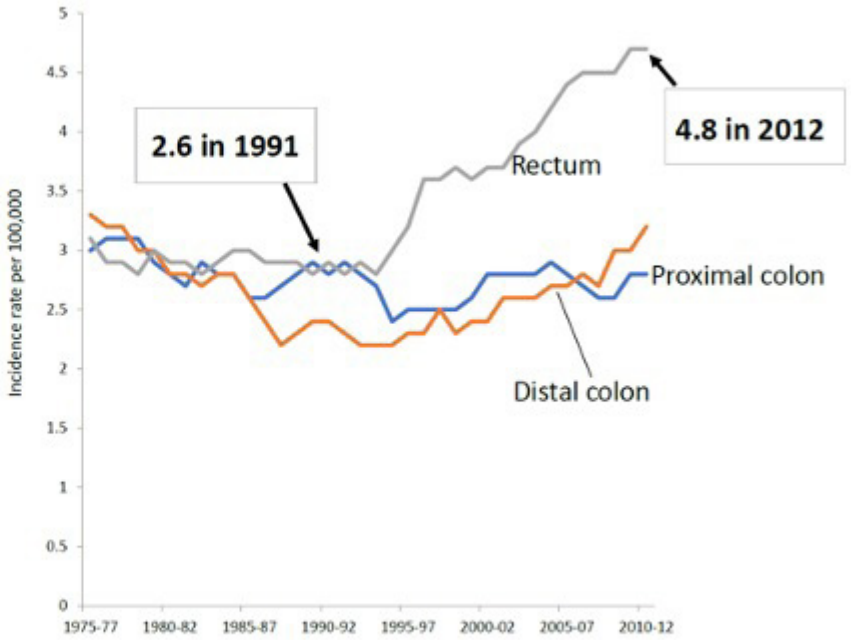
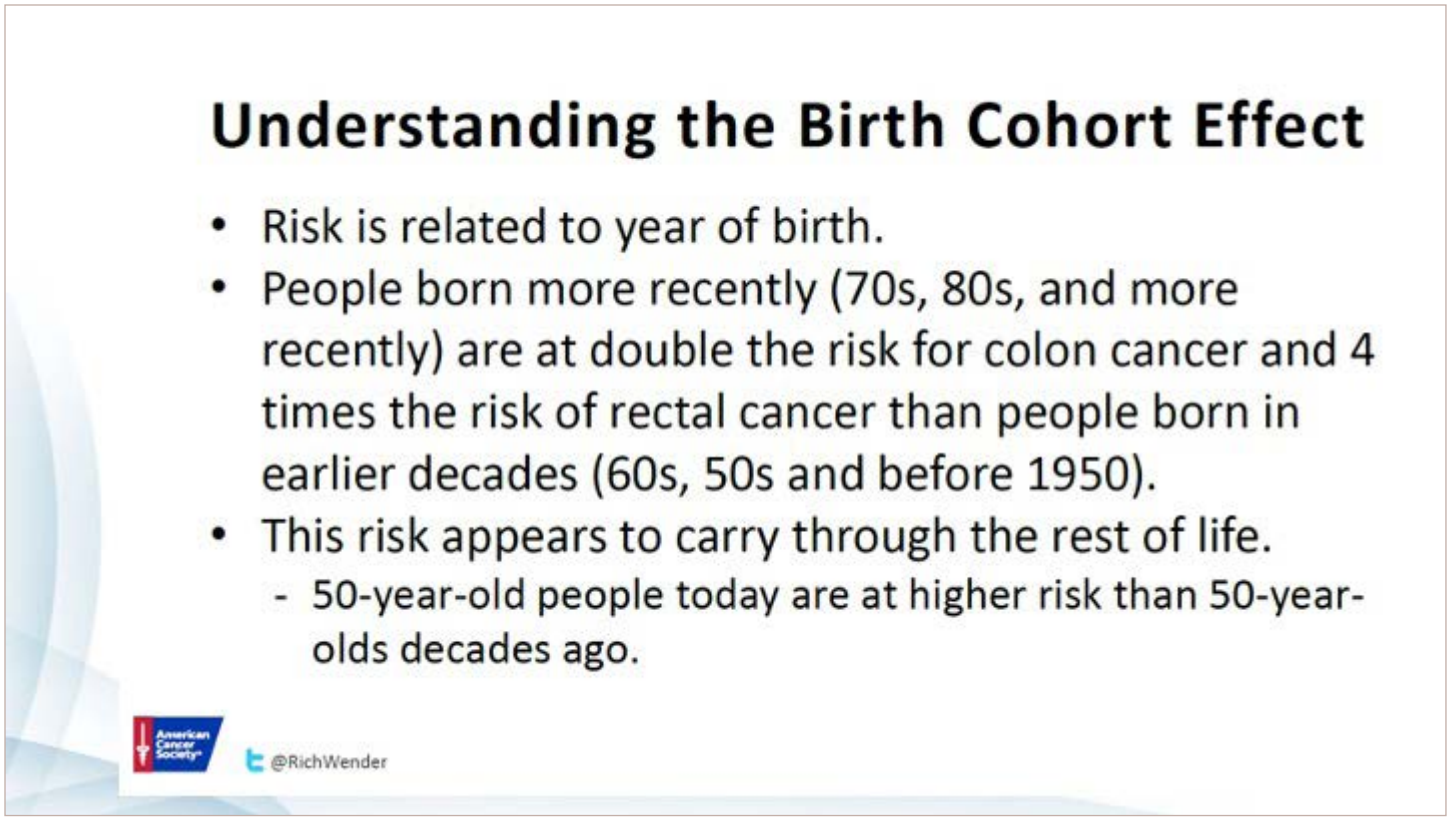
Incidence Trend in <50 Years by Tumor Subsite

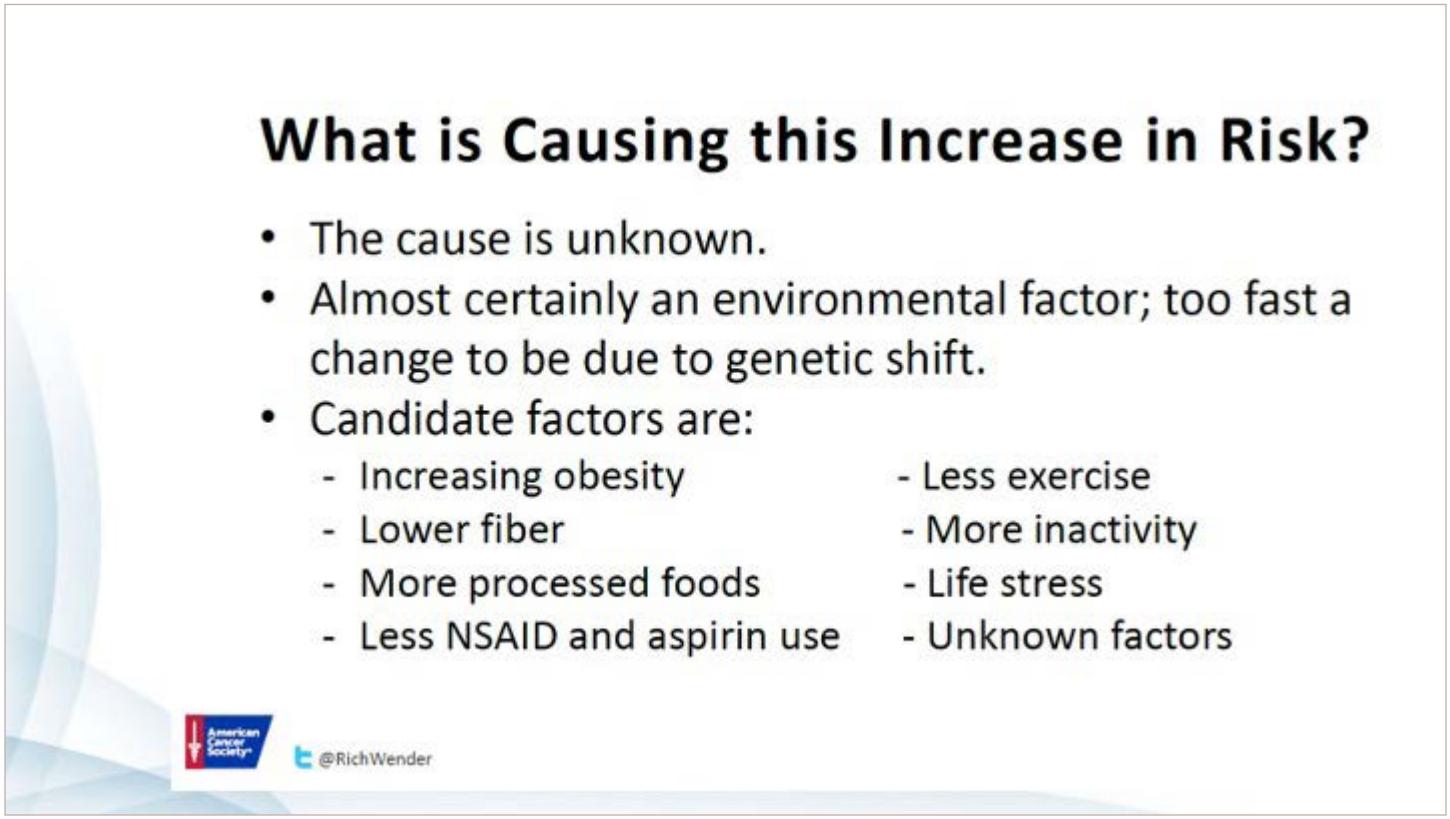


@RichWender

Source: SEER 9 delay-adjusted rates, 1975-2012; 3-year moving average.

68


Understanding the Birth Cohort Effect
• Risk is related to year of birth.
• People born more recently (70s, 80s, and more recently) are at double the risk for colon cancer and 4 times the risk of rectal cancer than people born in earlier decades (60s, 50s and before 1950).
• This risk appears to carry through the rest of life.
- 50-year-old people today are at higher risk than 50-year-olds decades ago.
@RichWender


What is Causing this Increase in Risk?
• The cause is unknown.
• Almost certainly an environmental factor; too fast a change to be due to genetic shift.
• Candidate factors are:
- Increasing obesity
- Lower fiber
- More processed foods
- Less NSAID and aspirin use
- Less exercise
- More inactivity
- Life stress
- Unknown factors
@RichWender

Insurance Coverage Update

- Two large insurers are covering all screening options according to the ACS guideline:
  - Aetna
  - CareFirst
- Maine passed a bill in May requiring most insurers to cover screening beginning at age 45.
- Other states have laws linking coverage to ACS guidelines.
- **All insurers will cover annual FIT testing with follow-up colonoscopy.**

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Colonoscopy and Stool Testing are Both Critical Strategies

Every system achieving 80% is relying on stool testing as well as colonoscopy.
Both approaches are critical.

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Stool Blood Testing Remains Important in the "Age of Colonoscopy"

- Colonoscopy is now the most frequently used screening test for CRC.
- However, when provided annually to average-risk patients with appropriate follow-up, stool occult blood testing with high-sensitivity tests can provide similar reductions in mortality compared to colonoscopy and some reduction in incidence.

@RichWender

Source: Evaluating Test Strategies for Colorectal Cancer Screening: A Decision Analysis for the U.S. Preventive Services Task Force

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We Must Ensure that Anyone Can Be Offered a Home Stool Blood Test

- Even if you recommend colonoscopy for all, some people won't get one, can't get one, or shouldn't get one.
- Using colonoscopy exclusively will, inevitably, lead to a screening gap.

@RichWender

102

Many Patients Prefer Home Stool Testing

Colonoscopy recommended:	38% completed colonoscopy
FOBT recommended:	67% completed FOBT
Colonoscopy or FOBT:	69% completed a test

@RichWender

Source: Adherence to Colorectal Cancer Screening: A Randomized Clinical Trial of Competing Strategies

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Fecal Immunochemical Tests (FITs) Should Replace Guaiac FOBT

FITs:

- Demonstrate superior sensitivity and specificity.
- Are specific for colon blood and are unaffected by diet or medications.
- Some can be developed by automated readers.
- Some improve patient participation in screening.

@RichWender

Sources: Allison JE, et.al. J Natl Cancer Inst. 2007; 191:1-9
Cole SR, et.al. J Med Screen. 2003; 10:117-122

AMGA current counts

AMGA Participant Service Area	Patient Count	Numerator	*Screening Rate	# Un-screened
Joplin	11,720	5,955	50.81%	5,765
Fort Smith	24,675	11,806	47.85%	12,869
East	127,522	77,319	60.63%	50,203
Springfield	66,754	43,828	65.66%	22,926
NWA	25,775	16,735	64.93%	9,040
West	57,331	33,728	58.83%	23,603
Mercy	313,777	189,371	60.35%	124,406

* AMGA excludes Sites of Care with <100 patients when drilling down. The overall Benchmark reports includes these so the numbers can vary between the two reports.

Manpower Shortage

Skilled scopist = 1,728 – 2,106 year (1,917)
- 8-10 screenings/day
- 4.5 days/week
- 48 weeks/year

# of FTE's needed
- Close Gap to 80% screening = 32.44
- Rescope @ 10%/yr = 9.9

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Colonoscopies for all? Practical Implications?

- Manpower shortage
- Cost of normal exams - Closing 80% gap
  - Cost net of FIT
    - MCR = $290.18
    - Fee = $1090.95
  - 75% of screening scopes = normal (ADR =25%)

Colonoscopy "cost" for normal

if MCR = $13,573,549.90

if Fee = $50,895,272.10

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What do we want?

Lead with FIT complete with colonoscopy

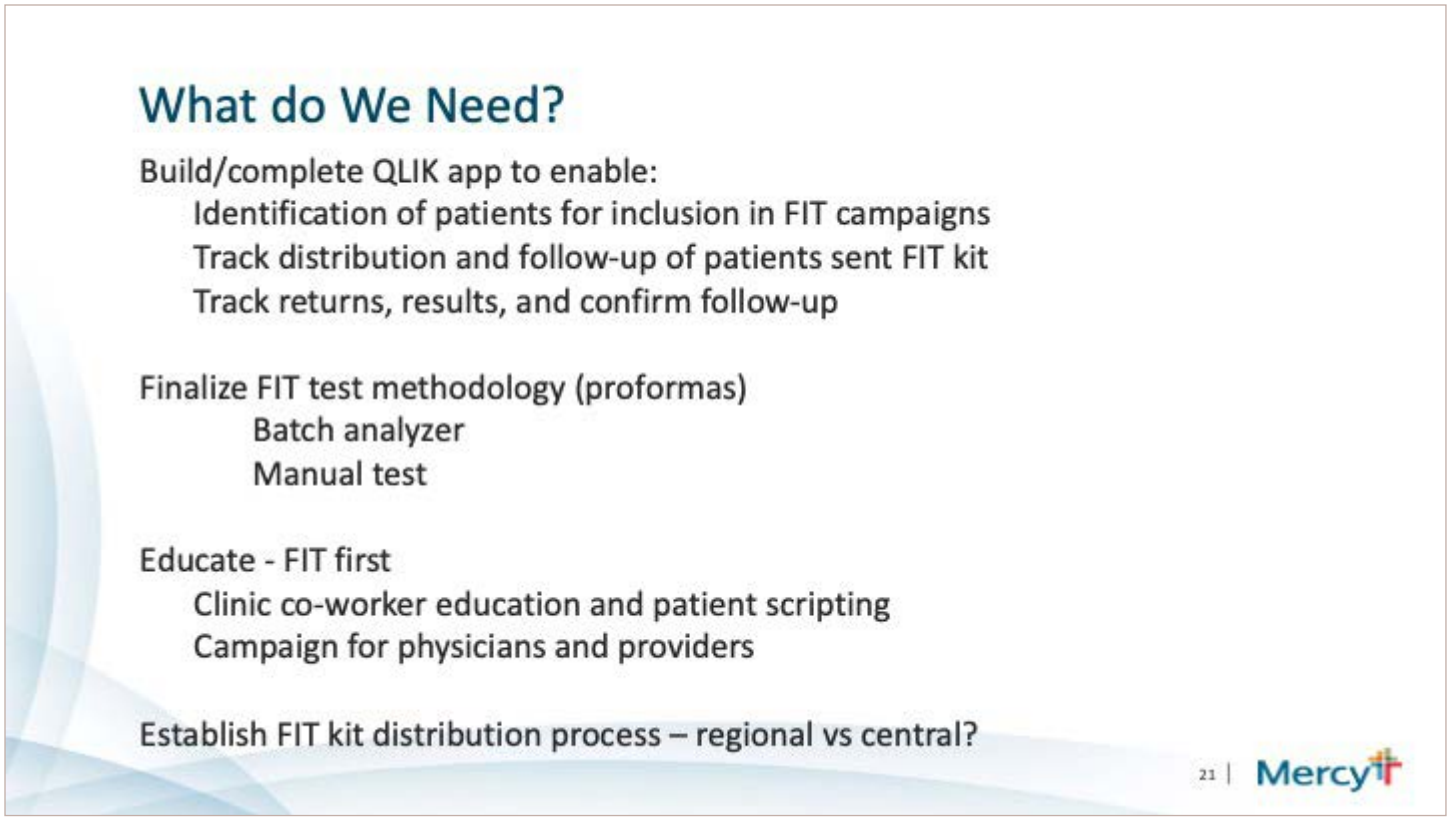
Standardize

- Tools
- Capture
- Results

Centralize the Management to reduce clinic burden

Drive better rates and save lives

20 | Mercy


What do We Need?
Build/complete QLIK app to enable:
Identification of patients for inclusion in FIT campaigns
Track distribution and follow-up of patients sent FIT kit
Track returns, results, and confirm follow-up
Finalize FIT test methodology (proformas)
Batch analyzer
Manual test
Educate - FIT first
Clinic co-worker education and patient scripting
Campaign for physicians and providers
Establish FIT kit distribution process – regional vs central?
21 | Mercy

CS08-1

Shared Decision-making Tool

Choosing which colorectal cancer screening option is right for you

SANFORD HEALTH

You can make choices about your health. Screening for colorectal cancer is recommended for everyone between the ages of 50 to 75. Choosing to do screening can save your life. Your age and other health factors affect when and how you should be screened.

Use this tool to talk to your doctor about 3 screening options. Each column below outlines 1 way to do screening. Compare each option to choose which screening method is best for you. Remember, the **best** screening option is the one that gets done!

Note: if you have a history of colorectal cancer or bowel disease, or have a close relative with colorectal cancer or polyps, a colonoscopy may be the best choice for you.

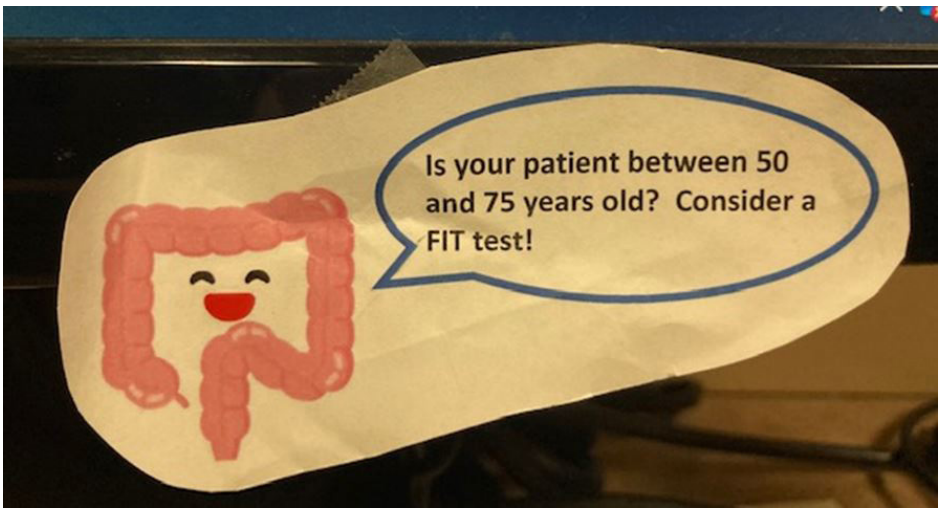
	FIT	Cologuard FIT-DNA	Colonoscopy
What is it?	Fecal Immunochemical Test: Stool is checked for blood (not seen by the naked eye) by taking a sample and mailing it in.	Stool is checked for cancer markers and blood (not seen by the naked eye) by taking a sample and mailing it in.	A lighted scope with a camera is used to look at the colon and rectum. This finds tissues and cells that are not normal.
Where is it done?	You collect a sample at home and return test kit to lab or mail it back (often pre-paid postage is included).	A test kit will be mailed to your home. You will collect a sample and mail the test kit back (address label and postage stamp included).	Your provider will give this test at the hospital in a procedure room. Medicines will be given to you to provide comfort.
How often?	Completed every 1-year if normal. *If test is not normal, you will need a colonoscopy.	Completed every 3-years if normal. *If test is not normal, you will need a colonoscopy.	Completed every 10-years if normal. *May include a biopsy or polyp removal if needed.
How do I get ready?	No preparation or diet restrictions required.	No preparation or diet restrictions required.	Requires fasting and a cleansing of the colon with a laxative.
What is the cost?	Low Cost – check with your insurance (often covered).	Variable cost – Check with insurance (sometimes covered).	Higher cost – check with insurance (often covered if qualified).

039051-00317 9/17

CS09-1

FIT Colon Reminder

The graphic is stuck to all the computers in the adult medicine clinic as a reminder to check CRC screening status.



CS09-2

Flyer promoting colorectal cancer screening to African American patients

CS09-3

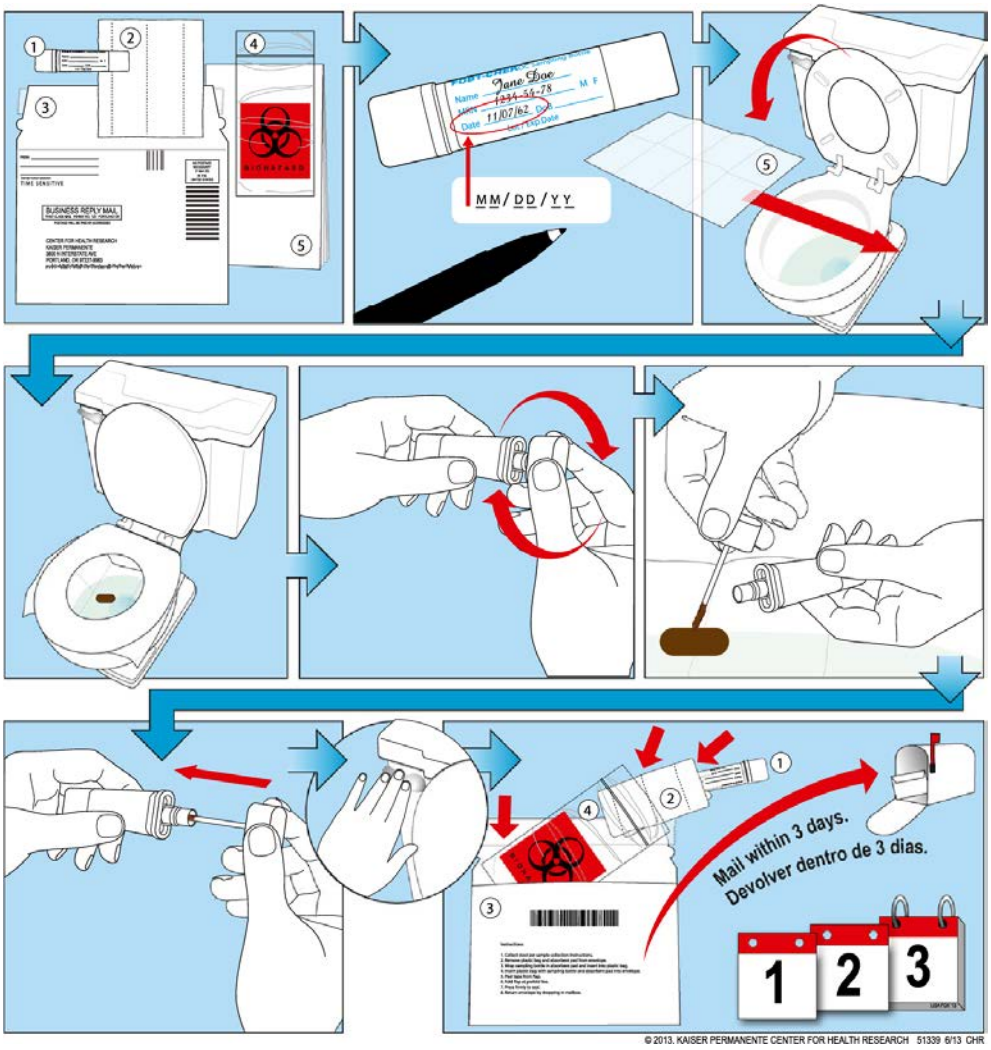
Mailed FIT workflow (used by MAs until centralized care coordination staff are available)

When order is sent it goes to a centralized work queue for mailing.

21 – 75

21-65 w/ cervix: Cervical Cancer Screen (Pap)
40-74 w/ breasts: Breast Cancer Screen (Mammo)
45-75: Colorectal Cancer Screen (FIT)

- Review relevant tabs (labs, imaging, etc) in Epic, Care Everywhere & Patient Archive
- Search item name in Epic search bar (ex: pap, mammogram, FIT, etc)
- Document most recent result in Epic Care Gap tab
- If due, pend/send orders to PCP or schedule visit
- Update documentation in Epic & create recall apt for appropriate follow-up



CS09-4

Wordless FIT instructions for patients

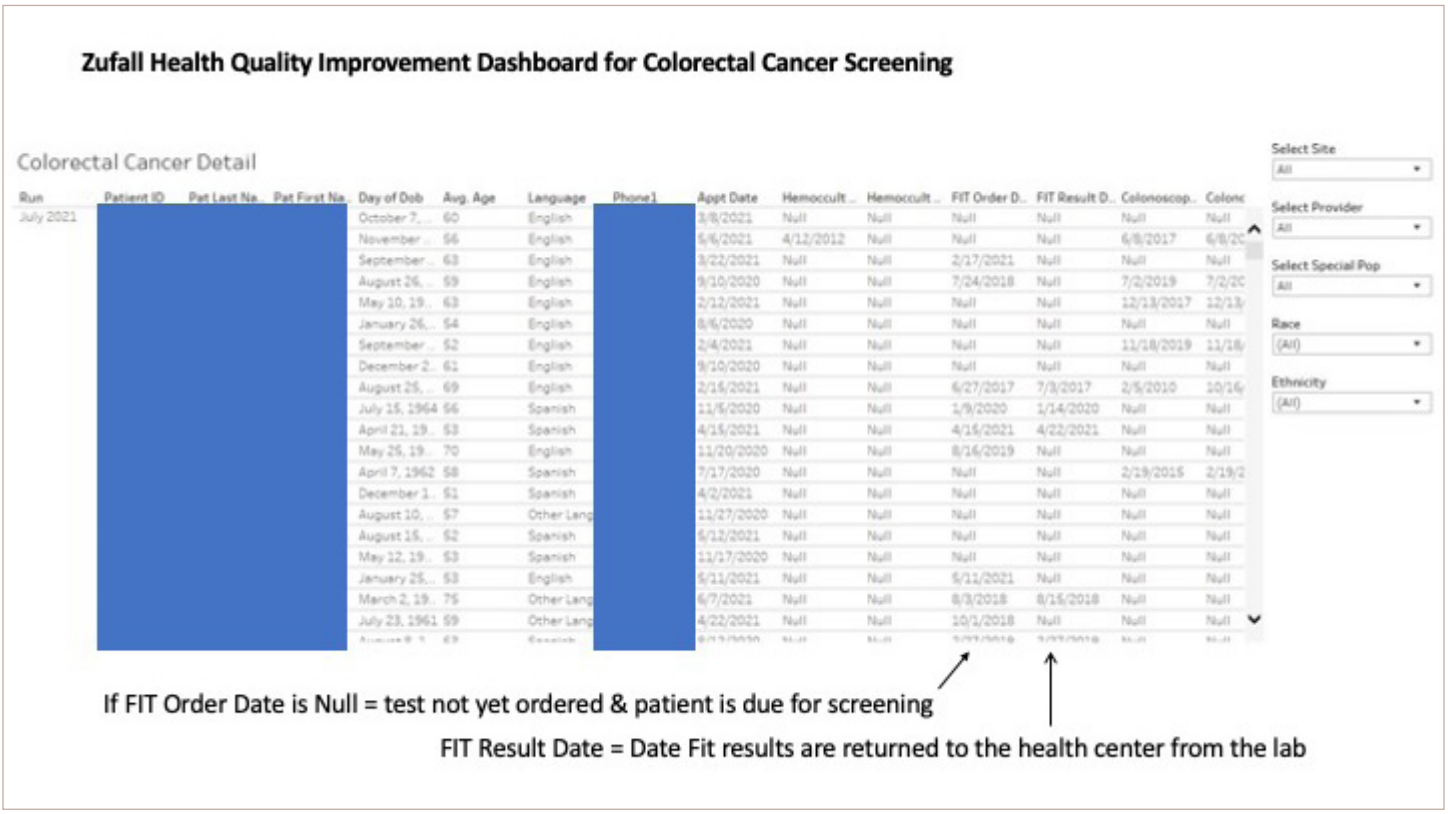
The health center uses the Kaiser Permanente Center for Health Research wordless FIT instructions.

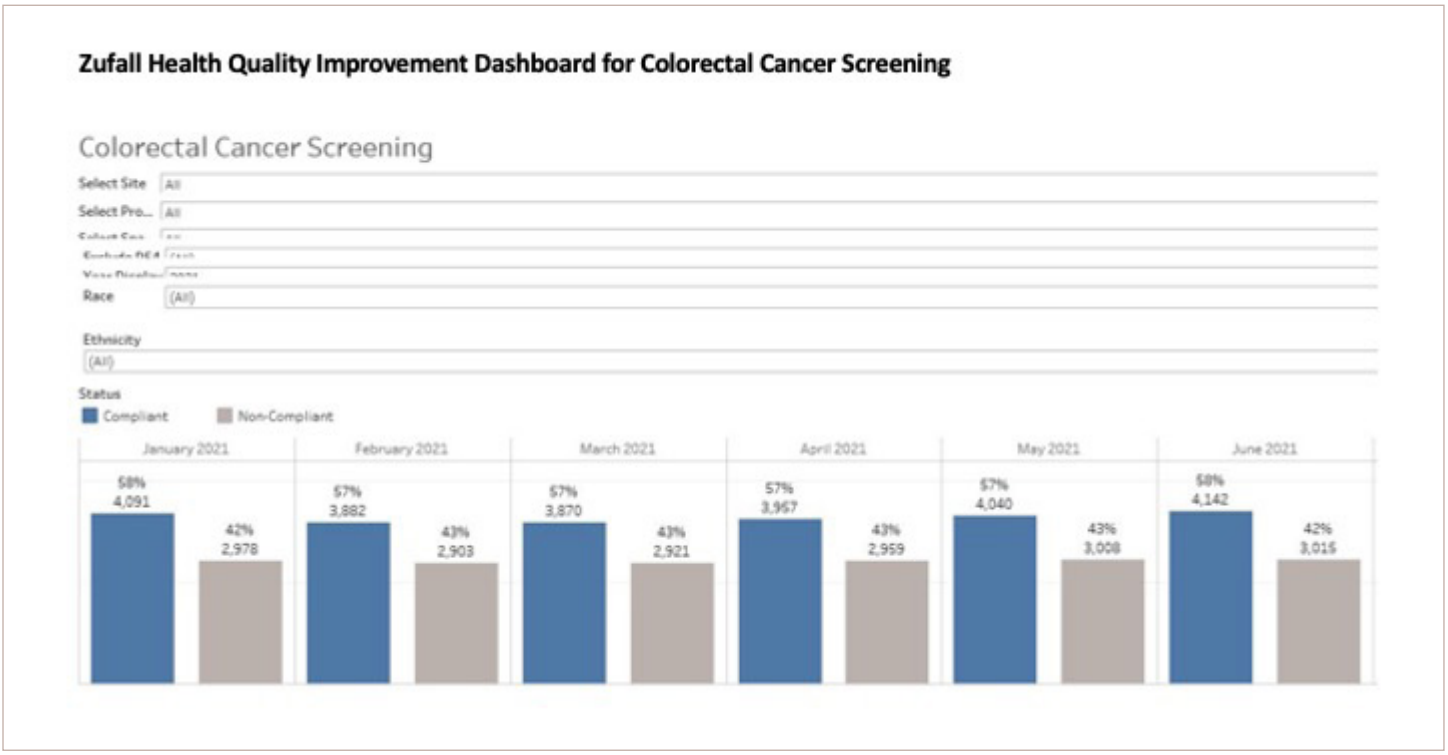
CS10-1

Contactless FIT drop-off box

CS10-2

Sample positive FIT dashboard used for quality improvement





CS10-3

Standing order policy for MAs

ZUFALL HEALTH

Standing Orders Policy

Reviewed 04/09/2021
Supersedes 05/12/2020
Page 3 of 6

Colon Screening for Patients 45 and older (until 75)
All patients 45 years and over need education on getting colon cancer screening, either with a FIT test annually or a colonoscopy every 3-10 years, depending on the risk of the patient and the results of previous colonoscopies. Patients, younger than 45, with specific health concerns, may be offered colon cancer screening.

To check if they have a colonoscopy in the chart, look under the DI tab and see if there is a colonoscopy result. Colonoscopy results should be attached to an order under DI for ease of locating the test and for reporting. If the report is not in DI, look under Patient Documents. If not on the chart but the patient says they had one, ask when and where they had their procedure and obtain consent for release of information. If it has been more than 10 years, they need to be screened again. If they cannot get the test result, advise them that they need to be screened again either with a FIT test or another colonoscopy.

- To order FIT, use the drop down menu under colon cancer screen in eCW to check off advice given.
- Then go to assessment, add Z12.11 and the order the *Fecal Immunochemical Test or FIT-FOBT IH (inhouse).
- If the provider agrees, discuss how to do the test with patient, including collecting the specimen and returning the cassette, at the end of the visit.

If the provider orders a GI consultation and colonoscopy instead, information regarding where and how to get the colonoscopy done will be given by the MA.

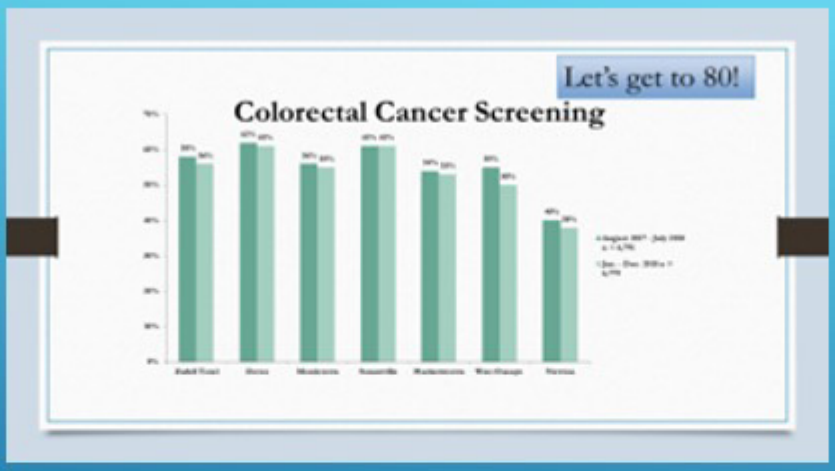
Please note that if a patient has a positive FIT test, the patient must get a colonoscopy. A repeat FIT test the following year is not indicated.

CS10-4

PowerPoint for MA training

- Navigator/Trainer
- Navigators at each site
- Identified GI specialists who will provide needed care to our patients who may have financial barriers to care.
- All Zufall team members including Providers and MA's who see the patients each and every day and can provide education and reinforce the importance of this screening to support this program

WHO WILL MAKE THIS HAPPEN?



CURRENT COLORECTAL SCREENING RATES BY SITE

- Patients between the ages of 45 and 75 years old who are screened using FIT (LabCorp) or FIT-FOBT (Insure FIT – inhouse) testing must be screened annually.
- Patients younger than 45 and between the ages of 76 and 85 will be screened at providers discretion based upon age and personal and/or family history.
- Patients who are screened using Colonoscopy must be screened every 10 years and do not need a FIT or FIT-FOBT testing in the interim unless deemed necessary by provider.
- If patient has been tested prior to becoming a Zufall Patient, please have patient sign release at first visit and request copies of any Colorectal screening results

WHO SHOULD BE SCREENED?— COLORECTAL SCREENING

Proposed Activities

- Provide FIT-FOBT tests to all of Zufall's eligible uninsured patients across all centers
- Conduct Patient Navigation to encourage return of tests
- Process the returned kits in house or prepare them for LabCorp
- Refer and navigate patients with positive result to colonoscopy services

Expected Outcomes

- CRC screening rates increase across Zufall's sites
- Let's get to 80%!!!!

COLORECTAL CANCER SCREENING

Activity

- FIT tests will be distributed and returns will be tracked in Zufall's EMR by staff
- Timeline will be as follows:
  - FIT kits given at any visit
  - Navigator will follow up at 3 days, 7 days and 14 days
  - Navigator will confirm lab results or follow up to request lab results 5 days after FIT return/delivery to lab

Outcome

- 5000 FIT kits will be distributed to our target patient population
- 3500 or more kits will be returned by our target population and processed

Review standing orders!

FIT TEST DISTRIBUTION

Activity

- Navigators will reach out to positive patients with follow-up reminders and assistance with further diagnostic testing, via phone and patient portal
- Zufall will provide 50 patients annually with $25 to eliminate the GI visit Copay
- Zufall will provide Financially indigent patients requiring colonoscopies with subsidies for up to $300 of copays

Outcome

- An estimated 280 patients with positive FIT tests will have access to Colonoscopies

FOLLOW UP

EXPENSES TO BE CHARGED TO GRANT

- FIT TEST Kits (In House) – for uninsured patients -$8.00 annually
- FIT TEST (Lab Processing) – for both insured and uninsured - $20 annually
- Staff travel to Training
- Patient Incentives: $10. gift cards for purchase of groceries to incentivize medially indigent patients to conduct and return their FIT tests to Zufall's Screen NJ patient navigators

BILLING

- All purchases/invoices related to the Screen NJ grant must have the following information noted on the PO
  - Date of purchase
  - Site
  - Screen NJ #658
- For example: ***01.31.2019DoverScreen NJ#658***

TO ORDER FROM MCKESSON

- Product #1099224
- 90025 Collection Kit InSure® ONE™ Colorectal Cancer Screening Fecal Occult Blood Test (iFOB or FIT) Stool Sample CLIA Waived 25 Collection Kits

- For most of you—navigator responsibilities should account for 20% of your schedule or approximately 8 hours per week.
- Somerville: Due to the presence of CEED at your site, ScreenNJ Navigation should account for 10% or approximately 4 hours per week.
- Schedules for participating in the Screen NJ project will be unique to each site and must be arranged with your site manager and ensure appropriate staffing at all times for each site.

HOW DOES THIS AFFECT YOUR SCHEDULE?

CS10-5

Sample patient text and voicemail reminders

Text Message

English	Our records show it is time for your colorectal cancer screening. Please call {{FACILITY_TELEPHONE}} to schedule an appointment.
Spanish	Nuestros registros indican que es tiempo de hacer su examen para detección de cáncer de colon. Por favor llame al (telephone number in Spanish) para hacer su cita.

Voice Message

English	Our records show it is time for your colorectal cancer screening. Please call {{FACILITY_TELEPHONE}} to schedule an appointment. Once again, the telephone number is {{FACILITY_TELEPHONE}}.
Spanish	Nuestros registros indican que es tiempo de hacer su examen para detección de cáncer de colon. Por favor llame al (telephone number in Spanish) para hacer su cita. Otra vez, el número de teléfono es (telephone number in Spanish).

CS10-6

Sample quarterly patient newsletter with article about FIT incentive

March 2021

This Month at Zufall

1 New Guidelines for Colorectal Cancer Screening

New guidelines from the American Cancer Society recommend that people at average risk of colorectal cancer start regular screening at age 45. Colorectal cancer is the third most common cancer in the United States. Screening is important because it can find cancer at an early stage when treatment works best. Two tests are available for screening:

- Fecal Immunochemical Test (FIT) - Looks for hidden blood in the stool, can be done at home, and should be done every year.
- Colonoscopy - Finds abnormal growths that can be removed before they turn into cancer. It is performed by a doctor and should be done every 5 to 10 years depending on your risk factors.

Talk to your provider about which test is right for you. For more information, visit http://bit.ly/2Mqgtjo.

2 Eat Less Salt for a Healthier Heart

A diet high in salt (also called sodium) can lead to high blood pressure and other serious illnesses. The American Heart Association recommends less than 2,300 milligrams, or a total of one teaspoon of salt, each day. Here are some ways to help you use less salt:

- Eat more fresh foods and fewer processed foods.
- Read food labels and choose "low sodium" or "no sodium" options.
- Cook fresh meals at home using little or no salt.
- Drain and rinse vegetables canned in salted water.
- Flavor foods with salt-free seasonings to enjoy strong flavors.

Zufall's Supplemental Nutrition Assistance Program Education (SNAP-Ed) team can help you choose healthier food options for good heart health. SNAP-Ed is a nutrition and physical activity program that teaches N.J. residents how to make healthy, budget-friendly food choices and lead more active lives. Virtual classes are free and open to the public. Learn more about SNAP-Ed classes: http://bit.ly/3spvxNm.

3 Free COVID Testing Still Available

Zufall is offering COVID testing at scheduled, off-site events in Morris and Sussex counties. Testing is available in Morris County at St. Margaret of Scotland Church in Morristown and Casa Puerto Rico in Dover. In Sussex County, residents can obtain tests at three alternating public sites in Augusta, Newton, and Sparta. You do not need to be a Zufall patient to get tested at these locations. Register for an appointment online at http://bit.ly/3ozafLl. Walk-ins are welcome.

Established patients can also get tested at most Zufall medical locations. Call to make an appointment: http://bit.ly/2U4KPJi.

All COVID testing will be a nasal swab. Rapid testing is NOT available. There is no charge for COVID testing. LabCorp bills insurers directly. If you're uninsured, the federal CARES Act will cover the fee. However, if your employer requires regular, repeat testing, you may not be covered.

Enrollment for health insurance has been extended through May 15. Visit www.getcovered.nj.gov. Need help? Call the Zufall Insurance Enrollment Hotline at 973-891-3425.

ZUFALL HEALTH COMMUNITY HEALTH CENTERS

zufallhealth.org

Follow us on:

marzo 2021

en Zufall

Detección

información, visite http://bit.ly/3qzpvsb.

ebas de COVID cuitas, Aún onibles

de COVID en eventos programados fuera s en los condados de Morris y Sussex. ponibles en el condado de Morris en la f Scotland en Morristown y en Casa Puerto ondado de Sussex, los residentes pueden tres sitios públicos alternos en Augusta, es necesario ser paciente de Zufall para estos lugares. Regístrese en línea para ly/3ozafLl. Las personas sin cita son

cidos también pueden hacerse la prueba en aciones médicas de Zufall. Llame para hacer 2U4KPJi.

son administradas con un hisopo nasal. O están disponibles. No hay cargo por LabCorp factura directamente a los ene seguro, la ley federal CARES cubrirá la su empleador requiere pruebas periódicas que no esté cubierto.

clases virtuales son gratuitas y abiertas al público. Obtenga más información sobre las clases de SNAP-Ed: http://bit.ly/3spvxNm.

La inscripción abierta para el Seguro de Salud se ha extendido hasta el 15 de mayo. Visite www.getcovered.nj.gov. Necesita ayuda? Llame a la línea directa de Inscripción al Seguro de Salud de Zufall (973) 891-3425.

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zufallhealth.org

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